Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration, Human Resources Division

Street Address

PO Box 997411, MS 1300, Sacramento, CA 95899-7411

Area Code/Phone Number: 916-552-8270

Email: ConflictOfInterestInquiry@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

■ Other NASADAD (Name)

1919 Pennsylvania Avenue, NW Suite M-250 (Address) Washington (City) D.C. (State) 20006 (Zip Code)

NASADAD fosters and supports the development of alcohol and other drug use prevention and treatment programs.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Arlington, VA (Location of Travel)

06/08/2025 - 06/12/2025 (Dates (month, day, year))

United Airlines (Transportation Provider)

☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

DoubleTree by Hilton Hotel (Name of Lodging Facility)

$450.00 (Lodging Expenses) $713.00 (Meal Expenses) $2,341.71 (Transportation Expenses) $_____ (Other Expenses) $3,504.71 (Total Expenses)

3.1 (b) Payment(s) not related to travel:

_____ (Dates (month, day, year)) $_____ (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

The officials were invited to represent California at annual National Association of State Alcohol and Drug Agency Directors conference as a requirement to get federal grants through the Substance Abuse and Mental Health Services Admin. Donor paid for hotel, meals, transportation and airfare.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
n/a	n/a	Staff Services Manager II	DHCS/Comm. Svcs. Div.
n/a	n/a	Staff Services Manager I	DHCS/Comm. Svcs. Div.

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

[redacted] (Signature) Erika Sperbeck (Print Name) Chief Deputy Director (Title) 10/28/25 (month, day, year)

Comment:

(Use this space or an attachment for any additional information)

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