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 Division, Human Resources Division

Street Address

P.O. Box 997411, MS 1300

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 National Academy for State Health Policy (Name)

1233 20th St., N.W., Suite 303 (Address) | Washington (City) | D.C. (State) | 20036 (Zip Code)

NASHP is a 501 (c)(3) nonprofit organization committed to advancing state health innovations and solutions.

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

Washington, D.C. (Location of Travel) | 02/24/2025 - 02/26/2025 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

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

Phoenix Park Hotel (Name of Lodging Facility)

$518.32	$118.00	$367.96	$	$1,004.28
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	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 Official was invited to speak at a contraceptive care access roundtable with other states about over-the-counter access to the OPill. Donor paid for lodging, meals, and transportation.

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

Last Name	First Name	Position/Title	Department/Division
Huang	Yingjia	Deputy Director, HCBE	Health Care Benefits & Elig.

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) | 04/23/25 (month, day, year)

Comment:

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

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