

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name
Department of Health Care Services
Division, Department, or Region (if applicable)
Administration, Human Resources Division
Street Address
P.O. Box 997411, MS 1300
Area Code/Phone Number (916) 552-8270
Email conflictofinterest@dhcs.ca.gov
Agency Contact (name and title)
Conflict of Interest Filing Officer
Date Stamp
California 801 Form
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual N/A
Other The Council of State Governments
1776 Avenue of the States Lexington KY 40511
Address City State Zip Code
Nonpartisan organization convenes policymakers for peer-to-peer learning to champion excellence in state government
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:
N/A

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Santa Fe, New Mexico Location of Travel
12/2/2021 and 12/4/2021 Dates (month, day, year)
United Airlines Transportation Provider
Rail Air Bus Auto Other
Check Applicable Boxes
Hilton Santa Fe Historic Plaza Name of Lodging Facility
\$228.57 Lodging Expenses
\$ Meal Expenses
\$929.30 Transportation Expenses
\$ Other Expenses
\$1,157.87 Total Expenses
3.1 (b) Payment(s) not related to travel:
N/A Dates (month, day, year)
\$ Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
Donor paid for airfare and hotel. Ms. Mollow was invited to speak at an educational conference, the 2021 CSG National Conference, which is directly related to DHCS' functions and duties.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Mollow Last Name
Rene First Name
Deputy Director, HCBE Position/Title
Health Care Services/DDO Department/Division
N/A Last Name
First Name
Position/Title
Department/Division

4. Verification

I have reported payment(s) as in compliance with FPPC regulations.
Erika Sperbeck Chief Deputy Director 01/20/22
Print Name Title (month, day, year)

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

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