Form 801 For Official Use Only  In in comment section) It (month, day, year)  In of Medicaid Directors  Name 20001 Zip Code It the District of Columbia  For this payment:  Amount
For Official Use Only  in in comment section)  (month, day, year)  on of Medicaid Directors  Name  20001  Zip Code  the District of Columbia  or this payment:  Amount
month, day, year)  on of Medicaid Directors  Name  20001  Zip Code  the District of Columbia  or this payment:  Amount
month, day, year)  on of Medicaid Directors  Name  20001  Zip Code  the District of Columbia  or this payment:  Amount
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Name 20001 Zip Code the District of Columbia or this payment:  \$
20001 Zip Code the District of Columbia or this payment:\$
the District of Columbia or this payment:  Amount
or this payment:  \$Amount
or this payment:  \$Amount
\$Amount
\$Amount
2/2040 06/44/2040
9/2019-06/11/2019 Dates (month, day, year)
vbird-Cliff Lodge
Name of Lodging Facility
\$ <del>764.61</del>
Total Expenses
Total Expenses
purpose and use.
OHCS/Health Care Program
Department/Division
N/A  Department/Division

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

Payment to Agency	Report	A Public Docur	nent		PAYMENT TO AGENCY REPORT
1. Agency Name				Date Stamp	California 201
Department of Healt	h Care Services			Form OUI	
Division, Department, or F	Region (if applicable)			For Official Use Only	
Administration Divisi Street Address	on, Human Resou	irces Branch			
P.O. Box 997411, M	IS 1300				
Area Code/Phone Numbe	r Email		ПА	mendment (ex	plain in comment section)
(916) 552-8270	ConflictofInte	rest@dhcs.ca.gov	-		3500
Agency Contact (name and title) Conflict of Interest Filing Officer				of Original Filir	ng: (month, day, year)
2. Donor Name and Add	Iress				
☐ Individual		[7] (	Other	nal Associat	ion of Medicaid Directors
Last Name		Name	Julei		Name
444 North Capitol Street,	Suite 524	Washington		DC	20001
Address		City		State	Zip Code
			s in 56 state	s, territories	& the District of Columbia
If "Other" is marked, describe the er	tity's business activity (if busin	ess) or its nature and interests.			
If applicable	e, identify the name of e	ach source and the amou	nt(s) received	I by the donor	for this payment:
Name	\$	Amount		Name	\$
	/Complete Section			Tallio	7 unount
3. Payment Information	Snowbird, UT		.3)	06/0	09/2019-06/11/2019
3.1 (a) Travel Payment	A STATE OF THE PARTY OF THE PAR	_ocation of Travel			Dates (month, day, year)
Southwest Airlines				Sno	wbird-Cliff Lodge
Transportation Provide	er Rail	☑ Air ☐ Bus ☐ Check Applicable Boxes	Auto 🔲	Other Sno	Name of Lodging Facility
\$ 357.16	45.00	352.00	10.00		764.16
Lodging Expenses	\$ Meal Expenses	Transportation Expenses		Expenses	STotal Expenses
3.1 (b) Payment(s) not	related to travel:			\$	
(a) . aj(o)		Dates (	month, day, year)	; · —	Total Expenses
3.2. Payment Description	on. Provide a specif	ic description of the	oayment an	d its agency	purpose and use.
Travel to attend 2019	NAMD Spring M	embershin meeting	in Snowh	ird LIT	
Traver to attenu 2013	5 NAME Spring IVI	embership meeting	III SHOWD	iiu, OT.	
0.0 [-]					
3.3. Identify the official					
Ducay	Robert		ant Deputy I		DHCS/Health Care Financin
Last Name	First Nam	e	Position/Title		Department/Division
N/A	N/A	N/A		1	N/A
Last Name	First Nam	ne	Position/Title		Department/Division
4. Verification					
authorized the acceptan	ce of the reported na	ument(s) as in compliar	nce with EDE	C regulation	ne.
71 aumonzeu me accepian		10.00			7 19 19
	Erika Sperb	Print Name	Chief Deput	Title	(month day year)
Signature		, mit wame		1140	(month, day, year)
Comment:					
(Use this space or an attachme	nt for any additional inform	ation)			FPPC Form 801 (Jan/14)
					advice@fppc.ca.gov

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Payment to Agency Rep	ort A Publ	ic Document	t	PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	Callifornia
Department of Health Ca			Form OUI	
Division, Department, or Region			For Official Use Only	
Administration Division, In Street Address	Human Resources Brai	nch	-	
P.O. Box 997411, MS 13	300			
Area Code/Phone Number   E	mail		☐ Amendment (	explain in comment section)
	ConflictofInterest@dho		to the second se	
Agency Contact (name and title)	0.00	Date of Original F	(month, day, year)	
Conflict of Interest Filing				
2. Donor Name and Address	Î		XI-21.4	
Individual	First Name	Other	National Associ	ation of Medicaid Directors
444 Capitol Avenue, Suite 524		gton	D	
Address	City		Sta	service services and services and services are services and services are services and services are services and services are services are services and services are services a
NAMD's sole function is to rep			6 states, territorie	s & the District of Columbia.
If "Other" is marked, describe the entity's bu	siness activity (if business) or its nature	e and interests.		
If applicable, iden	tify the name of each source a	and the amount(s) re	eceived by the done	or for this payment:
	\$			\$
Name	Amount	****	Name	Amount
<ol><li>Payment Information (Con</li></ol>		or b), 3.2, 3.3)		
3.1 (a) Travel Payment	Snowbird, Utah		<u>J</u> u	ine 9-11, 2019
Southwest	Location of Trave	el	0-	Dates (month, day, year)
Transportation Provider	Rail Air Check Applie	☐ Bus ☐ Auto	Other S	Name of Lodging Facility
357.16	.00 344.9		10.00	757.09
\$\$_N	5	\$_ ation Expenses	Other Expenses	\$Total Expenses
3.1 (b) Payment(s) not relate	d to travel:		\$	
		Dates (month, o		Total Expenses
3.2. Payment Description. P	rovide a specific descript	ion of the payme	ent and its agen	cy purpose and use.
To attend the NAMD 2019	9 Spring Membership N	Meeting in Sno	wbird, Utah.	
3.3. Identify the officials who	used the payment in Sec	ction 3.1 (See instruc	ctions)	
Cantwell	Marianne	Chief Deput	y Director	Health Care Programs
Last Name	First Name	Posil	tion/Title	Department/Division
Last Name	First Name	Posi	ition/Title	. Department/Division
I. Verification				
Lauthorized the acceptance of	the reported payment(s) as	in compliance wil	th FPPC regulation	ons.
	Erika Sperbeck	20	Deputy Director	7.19.19
Signature	Print Name		Title	(month, day year)
Comment:				
(Use this space or an attachment for an	ny additional information)			

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