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 Branch

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

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

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

2. Donor Name and Address

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

☑ Other National Association of Medicaid Directors (Name)

444 North Capitol Street, Suite 524 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent & support the Medicaid Directors in 56 states, territories & the District of Columbia

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 Snowbird, UT (Location of Travel) 06/09/2019-06/11/2019 (Dates (month, day, year))

Southwest Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Snowbird-Cliff Lodge (Name of Lodging Facility)

$357.16 (Lodging Expenses) $45.00 (Meal Expenses) $352.45 (Transportation Expenses) $10.00 (Other Expenses) $764.61 (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.

Travel to attend 2019 NAMD Spring Membership meeting in Snowbird, UT.

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	Senior Advisor	DHCS/Health Care Program
N/A	N/A	N/A	N/A

4. Verification

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

[redacted] Erika Sperbeck (Print Name) Chief Deputy Director (Title) 7.19.19 (month, day, year)

Comment:

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

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

3.1 (a) Travel Payment

Snowbird, UT (Location of Travel) | 06/09/2019-06/11/2019 (Dates (month, day, year))

Southwest Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Snowbird-Cliff Lodge (Name of Lodging Facility)

$357.16	$45.00	$352.00	$10.00	$764.16
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.

Travel to attend 2019 NAMD Spring Membership meeting in Snowbird, UT.

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

Last Name	First Name	Position/Title	Department/Division
Ducay	Robert	Assistant Deputy Director	DHCS/Health Care Financin
N/A	N/A	N/A	N/A

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) | 7.19.19 (month, day, year)

Comment:

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☐ Individual _____ (Last Name) _____ (First Name) ☑ Other National Association of Medicaid Directors (Name)

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

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

3.1 (a) Travel Payment

Snowbird, Utah (Location of Travel) June 9-11, 2019 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Snowbird - Cliff Lodge (Name of Lodging Facility)

$357.16 (Lodging Expenses) $45.00 (Meal Expenses) $344.93 (Transportation Expenses) $10.00 (Other Expenses) $757.09 (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.

To attend the NAMD 2019 Spring Membership Meeting in Snowbird, Utah.

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

Last Name	First Name	Position/Title	Department/Division
Cantwell	Marianne	Chief Deputy Director	Health Care Programs

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) 7.19.19 (month, day, year)

Comment:

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

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