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) | D.C. (State) | 20001 (Zip Code)

NAMD's sole function is to represent and 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

Denver, CO (Location of Travel) | 04/26-28/2017 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Renaissance Denver Downtowr (Name of Lodging Facility)

$408.51	$62.00	$638.62	$	$1,109.13
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.

To attend NAMD's Workshop on Alternative Payment Models in Medicaid in Denver from April 27-28, 2017.

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

Brooks	Sarah	Deputy Director	Health Care Delivery Systen
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division

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) | 7.26.17 (month, day, year)

Comment:

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

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