Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name
California Health and Human Services

Division, Department, or Region (if applicable)
CA. Department of Health Care Services

Street Address
1501 Capitol Avenue, Suite 6001

Area Code/Phone Number
916-440-7418

Email
marianne.cantwell@dhcs.ca.gov

Agency Contact (name and title)
Sandra Sabanovich, Executive Assistant

☐ **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 Director's (Name)

Address	City	State	Zip Code
444 N. Capitol Street, NW, Suite 524	Washington	DC	20001

The National Association of Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representati

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

Location of Travel: Sacramento, CA. to Chicago, Il.
Dates (month, day, year): 06/06/15 - 06/09/15

Transportation Provider: United Airlines

Check Applicable Boxes: ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other

Name of Lodging Facility: Hilton Double Tree - Magnificen

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$ 670.47	$ 143.00	$ 572.20	$ 113.36	$ 1,499.03

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.

CA. State Medicaid Director Mari Cantwell will participate in a panel discussion and attend the NAMD 2015 Spring Conference.

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 (Mari)	State Medicaid Director	Dept. of Health Care Service

4. Verification

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

Signature	Print Name	Title	(month, day, year)
[signature]	Karen Johnson	Chief Deputy Director	07/30/15

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