

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 Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address

Individual Other National Association of Medicaid Directors
Last Name First Name Name
601 New Jersey Avenue, NW Suite 740 Washington DC 20001
Address City State Zip Code

NAMD addresses the myriad content areas and issues that impact Medicaid Directors and their teams.

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 Savannah, GA 2/16-19/2022
Location of Travel Dates (month, day, year)
United and Southwest Airlines Rail Air Bus Auto Other Westin Savannah Harbor
Name of Lodging Facility
\$ 421.80 \$ 105.00 \$ 294.41 \$ 75.65 \$ 896.86
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.

Attendance of the Public Health Emergency Unwinding Workshop.

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

Cooper Jacey State Medicaid Director Health Care Services
Last Name First Name Position/Title Department/Division

4. Verification

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

Erika Sperbeck Erika Sperbeck Chief Deputy Director 04/15/22
Signature Print Name Title (month, day, year)

Comment:

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

