# 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, Human Resources Division

**Street Address**

P.O. Box 997411, MS 1300

| **Area Code/Phone Number** | **Email** |
|---|---|
| (916) 552-8270 | 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 St., NW Suite 267 (Address) Washington (City) DC (State) 20001 (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**

Washington, DC (Location of Travel) 11/13-16/2021 (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Renaissance Washington, DC (Name of Lodging Facility)

$807.00 (Lodging Expenses) $_____ (Meal Expenses) $_____ (Transportation Expenses) $500.00 (Other Expenses) $1,307.00 (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 National Association of Medicaid Directors Fall 2021 Conference.

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

| Last Name | First Name | Position/Title | Department/Division |
|---|---|---|---|
| Palav | Babaria | Deputy Director | Health Care Services |
| | | | |

## 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) 01/25/22 (month, day, year)

Comment:

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



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