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. Agency Name	Report	A Public Do		er antiket televitet i 140 Settekan kan pantasy		PAYMENT TO AGENCY REP
Department of Health Care	Services			Date St	amp	California Form 80
Division, Department, or Re			-			For Official Use Only
Administration, Human Re			120			
Street Address						
P.O. Box 997411, MS 1300	0					
Area Code/Phone Number	Email					
(916) 552-8270	conflictofinterest	@dhcs.ca.gov		Amendm	ent (explain i	n comment section)
Agency Contact (name and title))			Date of Origin	nal Filing: _	
Conflict of Interest Filing O	fficer					(month, day, year)
Donor Name and Addre	ess					
🗌 Individual			Cthor	National Ass	sociation of	of Medicaid Directors
Last Name		t Name	Other			ame
444 North Capitol St., NW	Suite 267	Washington		-	DC	20001
		City			State	Zip Code
NAMD addresses the myri				d Directors ar	nd their te	ams.
If applicable,	identify the name of e	each source and the		ceived by the	donor for tl	nis payment:
If applicable,	identify the name of e	each source and the		ceived by the	donor for tl	nis payment: \$
Name	\$	Amount	amount(s) re		donor for tl	\$
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Last Name	First Name	Position/Title	Department/Division
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	e of the reported payment(s) as in c		
	e of the reported payment(s) as in c Erika Sperbeck	compliance with FPPC regulations. Chief Deputy Director	01/25/22

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

FPPC Form 801 (Jan/18) advice@fppc.ca.gov