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 St., NW, Suite 267 — Address
Washington — City
DC — State
20001 — Zip Code

NAMD's sole function is to represent and support the Medicaid Director's in 50 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

Minneapolis, Minnesota — Location of Travel

08/07/19-08/09/19 — Dates (month, day, year)

Delta Airlines — Transportation Provider

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

Loews Minneapolis Hotel — Name of Lodging Facility

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$341.72	$80.00	$591.95	$	$1,013.67

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 the NAMD work group in Minneapolis, Minnesota.

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

Last Name	First Name	Position/Title	Department/Division
Cantwell	Mari	Chief Deputy Director	Health Care Programs

4. Verification

[redacted] reported payment(s) as in compliance with FPPC regulations.

Signature	Print Name	Title	(month, day, year)
[redacted]	Erika Sperbeck	Chief Deputy Director	10.21.19

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

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

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