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)

Address	City	State	Zip Code
444 North Capitol St., NW, Suite 267	Washington	DC	20001

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

Location of Travel: Minneapolis, Minnesota

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

Transportation Provider: Delta Airlines

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

Name of Lodging Facility: Loews Minneapolis Hotel

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$341.72	$80.00	$486.59	$127.44	$1,035.75

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
Retke	Michelle	Chief	Managed Care Operations

4. Verification

I authorized the acceptance of the 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)

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