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)

Administrative 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 N Capitol S NW Ste 524 (Address) Washington, D.C. (City) 20001 (State / 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, MN (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 Minnneapolis Hotel (Name of Lodging Facility)

$341.72	$80.00	$629.08	$12.00	$1,062.80
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.

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
Brooks	Sarah	Deputy Director	Health Care Services

4. Verification

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

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

Comment:

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

Clear Page