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

PO Box 997411, MS 1300, Sacramento, CA 95899-7411

Area Code/Phone Number

916-552-8270

Email

ConflictofInterestInquiry@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

601 New Jersey Avenue, NW Suite 740 — Address
Washington — City
D.C. — 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

St. Louis, Missouri — Location of Travel

03/29/26 - 03/31/26 — Dates (month, day, year)

Southwest Airlines — Transportation Provider

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

Westin St. Louis — Name of Lodging Facility

$716.00 — Lodging Expenses
$______ — Meal Expenses
$1,227.20 — Transportation Expenses
$150.00 — Other Expenses
$2,093.20 — 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.

The Officials were invited to participate in national dialogue respective to their areas of expertise. Donor paid for the transportation, lodging and provided a daily stipend.

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

Last Name	First Name	Position/Title	Department/Division
Taylor	Crystal	Deputy Director, CIO	DHCS/ETS
Khokhobashvili	Krissi	Deputy Director	DHCS/Office of Comms

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]	Lindy Harrington	Chief Deputy Director	7/21/26

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

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