

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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		Date Stamp	California Form 801 For Official Use Only
☐ Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)			

2. Donor Name and Address

☐ Individual _____ ☒ Other National Association of Medicaid Directors
 Last Name First Name Name
 601 New Jersey Avenue, NW Suite 740 Washington D.C. 20001
 Address City State 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 03/29/2026 - 03/31/2026
 Location of Travel Dates (month, day, year)
 Southwest Airlines ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other Westin St. Louis
 Transportation Provider Check Applicable Boxes Name of Lodging Facility
 \$716.00 \$ _____ \$1,261.20 \$300.00 \$2,277.20
 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.

The Officials were invited to participate in national dialogue respective to their areas of expertise. Donor paid for transportation, lodging, and provided a daily stipend of \$150 per traveler.

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

Huang	Yingjia	Deputy Director	DHCS/HCBE
Last Name	First Name	Position/Title	Department/Division
Walker	Lori	Deputy Director, CFO	DHCS/Fiscal
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

_____	Lindy Harrington	Chief Deputy Director	7/21/26
Signature	Print Name	Title	(month, day, year)

Comment:

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