

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 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
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 [x] National Association of Medicaid Directors
Last Name First Name Name
444 North Capitol Street, Suite 524 Washington D.C. 20001
Address City State Zip Code
NAMD's sole function is to represent and support the Medicaid Directors in 56 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:

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Denver, CO Location of Travel
04/26-28/2017 Dates (month, day, year)
United Airlines Transportation Provider
Rail [] Air [x] Bus [] Auto [] Other []
Check Applicable Boxes
Renaissance Denver Downtown Name of Lodging Facility
\$408.51 Lodging Expenses \$62.00 Meal Expenses \$638.62 Transportation Expenses \$ Other Expenses \$1,109.13 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 NAMD's Workshop on Alternative Payment Models in Medicaid in Denver from April 27-28, 2017.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Brooks Sarah Deputy Director Health Care Delivery System
Last Name First Name Position/Title Department/Division

4. Verification
Authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.
Signature Erika Sperbeck Chief Deputy Director
7.26.17 (month, day, year)

Comment:
(Use this space or an attachment for any additional information)
FPPC Form 801 (Jan/14) advice@fppc.ca.gov