

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b> California Health and Human Services		Date Stamp	<b>California Form 801</b> For Official Use Only
Division, Department, or Region (if applicable) CA. Department of Health Care Services			
Street Address 1501 Capitol Avenue, Suite 6001			
Area Code/Phone Number 916-440-7418	Email marianne.cantwell@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Sandra Sabanovich, Executive Assistant			

2. Donor Name and Address

Individual \_\_\_\_\_  Other National Association of Medicaid Director's

\_\_\_\_\_ Last Name First Name \_\_\_\_\_ Name

444 N. Capitol Street, NW, Suite 524 Washington DC 20001

Address City State Zip Code

The National Association of Medicaid Directors (NAMMD) is a bipartisan, professional, nonprofit organization of representati  
 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** Sacramento, CA. to Chicago, Il. 06/06/15 - 06/09/15

Location of Travel Dates (month, day, year)

United Airlines  Rail  Air  Bus  Auto  Other Hilton Double Tree - Magnificen

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 670.47	\$ 143.00	\$ 572.20	\$ 113.36	\$ 1,499.03
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.

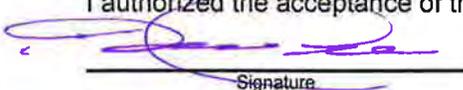
CA. State Medicaid Director Mari Cantwell will participate in a panel discussion and attend the NAMMD 2015 Spring Conference.

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

Cantwell	Marianne (Mari)	State Medicaid Director	Dept. of Health Care Service
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
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.

 Karen Johnson Chief Deputy Director 07/30/15

Signature Print Name Title (month, day, year)

Comment:

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