Payment to Agency Report　　**A Public Document**

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration, Human Resources Division

Street Address

P.O. Box 997411, MS 1300

Area Code/Phone Number	**Email**
(916) 552-8270	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　National Association of Medicaid Directors
　　　　Last Name　　　First Name　　　　　　　　　　　　　　Name

601 New Jersey Avenue, NW Suite 740　　Washington　　　DC　　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　Minneapolis, Minnesota　　　　5/15/23 - 5/19/23
　　　　　　　　　　　Location of Travel　　　　　　　Dates (month, day, year)

_____　☐ Rail ☐ Air ☐ Bus ☐ Auto ■ Other　Lowes Hotel
Transportation Provider　　Check Applicable Boxes　　　　　Name of Lodging Facility

$ 774.41　　　　$ _____　　$ _____　　　$ _____　　$ 774.41
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.

Official was invited to NAMD to collaborate on a wide variety of timely critical Medicaid topics.

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

Harrington	Lindy	Asst. State Medicaid Dir.	Director's Office
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.

████████	Erika Sperbeck	Chief Deputy Director	07/14/23
Signature	Print Name	Title	(month, day, year)

Comment:

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

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