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

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

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual — Last Name: N/A — First Name:

■ Other — Name: National Association of Medicaid Directors

Address: 601 New Jersey Avenue NW, Suite 740 — City: Washington — State: DC — Zip Code: 20001

Convenes Medicaid Directors to discuss cost-effective, efficient, and visionary ways to administer the Medicaid program.

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: N/A — $ Amount: — Name: — $ Amount:

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Location of Travel: Minneapolis, Minnesota

Dates (month, day, year): 5/16/23-5/19/23

Transportation Provider: Southwest Airlines

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

Name of Lodging Facility:

$ Lodging Expenses: — $ Meal Expenses: — $ Transportation Expenses: 724.39 — $ Other Expenses: — $ Total Expenses: 724.39

3.1 (b) Payment(s) not related to travel:

Dates (month, day, year): N/A

$ Total Expenses:

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Donor paid for airfare. Ms. Huang was invited to speak on eligibility redeterminations with regards to the Medicaid COVID unwinding at the NAMD 2023 Annual Membership Meeting, which is directly related to DHCS' functions and duties.

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

Last Name	First Name	Position/Title	Department/Division
Huang	Yingjia	Asst Dept. Dir, HCBE	Health Care Benefits & Elig.

4. Verification

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

[redacted] (Signature) — Erika Sperbeck (Print Name) — Chief Deputy Director (Title) — 07/14/23 (month, day, year)

Comment:

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

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