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 997413, MS 1300

Area Code/Phone Number: 916-552-8270

Email: ConflictofInterestInquiry@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) _____ (First Name)

■ Other National Association of Medicaid Directors (Name)

601 New Jersey Avenue, NW Suite 740 (Address) Washington (City) DC (State) 20001 (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

Chicago, IL (Location of Travel)

06/09/2025 - 06/11/2025 (Dates (month, day, year))

Alaska Airlines; United Airlines (Transportation Provider)

☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Swissotel Chicago (Name of Lodging Facility)

$479.32 (Lodging Expenses) $_____ (Meal Expenses) $563.78 (Transportation Expenses) $_____ (Other Expenses) $1,043.10 (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 Official has a scholarship with NAMD and was invited to collaborate on a wide variety of critical sessions on current and relevant topics. Donor paid for airfare and lodging.

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

Last Name	First Name	Position/Title	Department/Division
Sadwith	Tyler	State Medicaid Director	DHCS/Director's Office

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) 07/14/25 (month, day, year)

Comment:

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

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