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, Sacramento, CA 95899-7411

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)

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) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Denver, Colorado (Location of Travel)

07/10/23 - 07/12/23 (Dates (mon h, day, year))

United Airlines (Transportation Provider)

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

Hyatt Regency Denver (Name of Lodging Facility)

$495.41	$154.45	$576.57	$_____	$1,226.43
Lodging Expenses	Meal Expenses	Transporta ion 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.

Donor paid for airfare, lodging, and meals. Official was invited to speak on eligibility redeterminations with regard to the Medicaid COVID-19 unwinding at the NAMD 2023 Annual Membership Meeting.

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	Assistant Deputy Director	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)	10/20/23 (mon h, day, year)

Comment:

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

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