preference about medical treatment. The individual may make his preference known through the use of an advance directive, which is a written instruction prepared in advance, such as a living will or durable power of attorney. This information is documented in a prominent part of the individual's medical record. Advance directives as described in the Patient Self-Determination Act (enacted in 1991) have increased the individual's control over decisions concerning medical treatment. The advance directives requirement was enacted because Congress wanted individuals to know that they have a right to make health care decisions and to refuse treatment even when they are unable to communicate.; *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 33,096; *Total Annual Responses:* 33,096; *Total Annual Hours:* 924,120.

6. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Payment Adjustment for Sole Community Hospitals and Supporting Regulations in 42 CFR Section 412.92; *Form No.:* CMS–R–79 (OMB# 0938–0477); *Use:* This collection provides that if a hospital that is classified as a sole community hospital (SCH) experiences, due to circumstances beyond its control, a decrease of more than 5 percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may apply for a payment adjustment. To qualify for this adjustment to its payment rate an SCH must submit documentation, including cost information as requested by CMS, to the intermediary; *Frequency:* On occasion; *Affected Public:* Not-for-profit institutions, Business or other for-profit, and State, Local or Tribal Government; *Number of Respondents:* 40; *Total Annual Responses:* 40; *Total Annual Hours:* 160.

To obtain copies of the supporting statement and any related forms for these paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/regulations/pra/,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

Written comments and recommendations for these information collections will be considered if they are mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Christopher Martin, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: July 29, 2005.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 05–15505 Filed 8–4–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of a New System of Records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system titled ''Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (Section 1011),'' System No. 09–07–0546. The system will contain enrollment and payment request information, in support of a short-term program which pays hospitals, certain physicians, and ambulance providers (including Indian Health Service (IHS) facilities whether operated by the IHS or by an Indian Tribe or tribal organization) for their otherwise un-reimbursed costs of services provided under the provisions of section 1867 (Emergency Medical Treatment and Labor Act) (EMTALA) of the Social Security Act (the Act) and related hospital inpatient and outpatient services and ambulance services furnished to undocumented aliens, aliens paroled into the United States (U.S.) at a U. S. port of entry for the purposes of receiving such services, and Mexican citizens permitted temporary entry to the U.S. for not more than 30 days under the authority of a biometric machine readable border crossing identification card (also referred to as a ''laser visa'') issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act. This system is being established under provisions of Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 Modernization Act of 2003 (MMA).

The primary purpose of the system is to maintain information collected on individuals who submit an enrollment application and make payment requests associated with Section 1011 of the MMA, and other information designed to support the enrollment, claims payment, and research reporting functions of the Section 1011 program. Information retrieved from this system will also be disclosed to: (1) Support regulatory, payment activities, and policy functions performed within the agency or by a designated contractor or consultant; (2) combat fraud and abuse in certain health benefits programs; (3) assist another Federal or state agency with information to enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal; (4) funds support constituent requests made to a Congressional representative; and, (5) support litigation involving the agency. We have provided background information about the new system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that the ''routine use'' portion of the system be published for comment, CMS invites comments on all portions of this notice. See **DATES** section for comment period.

DATES: CMS filed a new system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on July 21, 2005. In any event, we will not disclose any information under a routine use until 40 days after publication. We may defer implementation of this system or one or more of the routine use statements listed below if we receive comments that persuade us to defer implementation.

ADDRESSES: The public should address comments to: CMS Privacy Officer, Division of Privacy Compliance Data Development (DPCDD), CMS, Mail Stop N2–04–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.–3 p.m., eastern time zone.

FOR FURTHER INFORMATION CONTACT: Section 1011 Project Officer, Center for Medicare Management, CMS, Mailstop C4–10–07, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

SUPPLEMENTARY INFORMATION: Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on

Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867 of the Act sets forth requirements for medical screening examinations of medical conditions, as well as necessary stabilizing treatment or appropriate transfer. In addition, section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status. Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals responsible for negligently violating a requirement of that section, through actions such as the following: (a) Negligently failing to appropriately screen an individual seeking medical care; (b) negligently failing to provide stabilizing treatment to an individual with an emergency medical condition; or (c) negligently transferring an individual in an inappropriate manner. (Section 1867(e)(4) of the Act defines ''transfer'' to include both transfers to other health care facilities and cases in which the individual is released from the care of the hospital without being moved to another health care facility.)

These provisions, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Congress enacted these antidumping provisions in the Act because of its concern with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance.

I. Description of the New System of Records

A. Statutory and Regulatory Basis for System

The authority to conduct the program is given under the provisions of Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173).

B. Collection and Maintenance of Data in the System

The Section 1011 program includes the provider name and identification number, provider address, provider employer identification number, provider banking information, provider federal tax identification number, patient's control number, medical record number, date of service, patient's gender, zip code, state and county, the principle diagnosis code, admitting diagnosis code, and total charges. It also includes claims information related to Section 1011 payment requests, and other research information needed to pay claims and administer the Section 1011 program.

II. Agency Policies, Procedures, and Restrictions on the Routine

The Privacy Act permits us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a ''routine use.'' The government will only release Section 1011 program information that can be associated with an individual provider as provided for under ''Section III. Entities Who May Receive Disclosures under Routine Use.'' Both identifiable and non-identifiable data may be disclosed under a routine use. Identifiable data includes individual records with Section 1011 program information and identifiers. Non-identifiable data includes individual records with Section 1011 program information and masked identifiers or Section 1011 program information with identifiers stripped out of the file.

We will only disclose the minimum personal data necessary to achieve the purpose of the Section 1011 program. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. In general, disclosure of information from the system will be approved only for the minimum information necessary to accomplish the purpose of the disclosure after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected; *e.g.*, to maintain information needed when submitting an enrollment application and make payment requests associated with Section 1011(a) of the MMA;.

2. Determines that:

a. The purpose for which the disclosure is to be made can only be accomplished if

b. The record is provided in individually identifiable form;

c. The purpose for which the disclosure is to be made is of sufficient importance to warrant the effect and/or risk on the privacy of the individual that additional exposure of the record might bring; and

d. There is a strong probability that the proposed use of the data would in fact accomplish the stated purpose(s).

3. Requires the information recipient to:

a. Establish administrative, technical, and physical safeguards to prevent unauthorized use of disclosure of the record;

b. Remove or destroy at the earliest time all patient-identifiable information; and

c. Agree to not use or disclose the information for any purpose other than the stated purpose under which the information was disclosed.

4. Determines that the data are valid and reliable.

III. Proposed Routine Use Disclosures of Data in the System

A. Entities Who May Receive Disclosures Under Routine Use

These routine uses specify circumstances, in addition to those provided by statute in the Privacy Act of 1974, under which CMS may release information from the Section 1011 program without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors or consultants who have been contracted by the agency to assist in the performance of a service related to this system and who need to have access to the records in order to perform the activity.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual or similar agreement with a third party to assist in accomplishing agency business functions relating to purposes for this system of records.

CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor whatever information is necessary for the

contractor to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor from using or disclosing the information for any purpose other than that described in the contract and requires the contractor to return or destroy all information at the completion of the contract.

2. To a CMS contractor that assists in the administration of a CMS-administered health benefits program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual relationship or grant with a third party to assist in accomplishing CMS functions relating to the purpose of combating fraud and abuse.

CMS occasionally contracts out certain of its functions and makes grants when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor or grantee whatever information is necessary for the contractor or grantee to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor or grantee from using or disclosing the information for any purpose other than that described in the contract and requiring the contractor or grantee to return or destroy all information.

3. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

Other agencies may require Section 1011 program information for the purpose of combating fraud and abuse in such Federally-funded programs. Releases of information would be allowed if the proposed use(s) for the information proved compatible with the purposes of collecting the information.

4. To another Federal or state agency to:

a. Contribute to the accuracy of CMS'' proper payment of a health benefit, or

b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds.

Other Federal or state agencies in their administration of a Federal health program may require Section 1011 program information in order to ensure that proper payment for services were provided. Releases of information would be allowed if the proposed use(s) for the information proved compatible with the purpose for which CMS collects the information.

5. To a Member of Congress or to a congressional staff member in response to an inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.

Individuals sometimes request the help of a Member of Congress in resolving some issue relating to a matter before CMS. The Member of Congress then writes CMS, and CMS must be able to give sufficient information to be responsive to the inquiry.

6. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity; or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government;

Is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation.

Whenever CMS is involved in litigation, or occasionally when another party is involved in litigation and CMS' policies or operations could be affected by the outcome of the litigation, CMS would be able to disclose information to the DOJ, court or adjudicatory body involved. A determination would be made in each instance that, under the circumstances involved, the purposes served by the use of the information in the particular litigation is compatible with a purpose for which CMS collects the information.

B. Additional Provisions Affecting Routine Use Disclosures

This system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, 65 FR 82462 (12–28–00), Subparts A and E. Disclosures of PHI authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.''

In addition, our policy will be to prohibit release even of not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary).

IV. Safeguards

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations include but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent NIST publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

V. Effects of the New System on Individual Rights

CMS proposes to establish this system in accordance with the principles and requirements of the Privacy Act and will collect, use, and disseminate

information only as prescribed therein. Data in this system will be subject to the authorized releases in accordance with the routine uses identified in this system of records.

CMS will monitor the collection and reporting of Section 1011 data. Section 1011 information on patients is submitted to CMS in a standard payment system. Accuracy of the data is important since incorrect information could result in the wrong payment for services. CMS will utilize a variety of onsite and offsite edits and audits to increase the accuracy of Section 1011 payment requests.

CMS will take precautionary measures (see item IV. above) to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights of patients whose data is maintained in the system. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act.

CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of maintaining this system of records.

Charlene Brown,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0546

SYSTEM NAME:

''Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (Section 1011)'' HHS/CMS/CMM.

SECURITY CLASSIFICATION:

Level 3, Privacy Act Sensitive.

SYSTEM LOCATION:

CMS Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850 and CMS contractors and agents at various locations.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

The Section 1011 program will include information on individuals who have elected to participate in the Section 1011 program, claims information related to Section 1011 payment requests, and information needed to pay claims and administer the Section 1011 program.

CATEGORIES OF RECORDS IN THE SYSTEM:

The Section 1011 program includes the provider name and identification number, provider address, provider employer identification number, provider banking information, provider Federal tax identification number, patient's control number, medical record number, date of service, patient's gender, zip code, state and county, the principle diagnosis code, admitting diagnosis code, and total charges. It also includes claims information related to Section 1011 payment requests, and other research information needed to pay claims and administer the Section 1011 program.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

The authority to conduct the program is given under the provisions of Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173).

PURPOSE (S) OF THE SYSTEM:

The primary purpose of the system is to maintain information collected on individuals who submit an enrollment application and make payment requests associated with Section 1011 of the MMA, and other information designed to support the enrollment, claims payment, and research reporting functions of the Section 1011 program. Information retrieved from this system will also be disclosed to: (1) Support regulatory, payment activities, and policy functions performed within the agency or by a designated contractor or consultant; (2) combat fraud and abuse in certain health benefits programs; (3) assist another Federal or state agency with information to enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal; (4) funds support constituent requests made to a Congressional representative; and, (5) support litigation involving the agency.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

A. Entities Who May Receive Disclosures Under Routine Use

These routine uses specify circumstances, in addition to those provided by statute in the Privacy Act of 1974, under which CMS may release information from the Section 1011 program without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors or consultants who have been contracted by the agency to assist in the performance of a service related to this system and who need to have access to the records in order to perform the activity.

2. To a CMS contractor that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

3. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

4. To another Federal or State agency to:

a. Contribute to the accuracy of CMS' proper payment of a health benefit, or

b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds.

5. To a Member of Congress or to a congressional staff member in response to an inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.

6. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity; or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government;

Is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation.

B. Additional Provisions Affecting Routine Use Disclosures

This system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, 65 FR 82462 (12–28–00), Subparts A and E. Disclosures of PHI authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.''

In addition, our policy will be to prohibit release even of not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All claim records are stored on magnetic media. Patient eligibility information may be maintained electronically or in paper format.

RETRIEVABILITY:

Providers will retrieve medical records by the patient control number. Provider IDs and patient control numbers are used to facilitate inquiries into specific claims as needed.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations include but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent NIST publications; the HHS Automated Information Systems Security Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

CMS will retain identifiable Section 1011 data for an indefinite period. Data residing with the designated claims payment contractor shall be returned to CMS at the end of the fifth program year, with all data then being the responsibility of CMS for adequate storage and security.

SYSTEM MANAGER AND ADDRESS:

Section 1011 Project Officer, Center for Medicare Management, CMS, 7500 Security Boulevard, Mail Stop C4–10–07, Baltimore, Maryland, 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, and for verification purposes, the subject individual's name and provider identification number and the patient's medical record number.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also reasonably specify the record contents being sought. (These procedures are in accordance with Department regulation 45 CFR 5b.5(a)(2).)

CONTESTING RECORD PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the record and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These procedures are in accordance with Department regulation 45 CFR 5b.7.)

RECORD SOURCE CATEGORIES:

Information maintained in this system will be collected from individuals volunteering to participate in Section 1011 program through the enrollment application and claims data requesting payment for services.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. 05–15165 Filed 8–4–05; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Compassion Capital Fund Evaluation—Initial Outcome Study.

OMB No.: New collection.

Description: This proposed information collection activity is for an initial outcome study that is one component of the evaluation of the Compassion Capital Fund (CCF) program. The information collection will be through mailed surveys to be completed by selected faith-based and community organizations that received sub-awards from CCF grantees. The CCF grantees are intermediary organizations that provide capacity building services to faith-based and community organizations.

The CCF evaluation is an important opportunity to examine the outcomes and effectiveness of the Compassion Capital Fund in meeting its objective of improving the capacity of faith-based and community organizations. This initial outcome study component of the evaluation will involve approximately 180 faith-based and community organizations. Information will be sought from these organizations to assess change and improvement in various areas of capacity resulting from receipt of sub-awards.

Respondents: The respondents will be selected faith-based and community organizations that received sub-awards in 2003 from nine selected CCF intermediary grantees. The surveys will be self-administered.