Supplementary Medical Insurance, provides a standardized form to satisfy the requirements of law as well as allowing both agencies to protect the individual from an inappropriate decision; Form Numbers: CMS–1763 (OMB #: 0938–0025; *Frequency:* Reporting—Once; Affected Public: Individuals or households; *Number of Respondents:* 14,000; *Total Annual Responses:* 14,000; *Total Annual Hours:* 5,831. (For policy questions regarding this collection contact Naomi Rappaport at 410–786–2175. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Disproportionate Share Adjustment Procedures and Criteria and Supporting Regulations in 42 CFR 412.106: *Use:* Section 1886(d)(5)(F) of the Social Security Act established the Medicare disproportionate share adjustment (DSH) for hospitals, which provides additional payment to hospitals that serve a disproportionate share of the indigent patient population. This payment is an add-on to the set amount per case CMS pays to hospitals under the Medicare Inpatient Prospective Payment System (IPPS).

Under current regulations at 42 CFR 412.106, in order to meet the qualifying criteria for this additional DSH payment, a hospital must prove that a disproportionate percentage of its patients are low income using Supplemental Security Income (SSI) and Medicaid as proxies for this determination. This percentage includes two computations: (1) the ''Medicare fraction'' or the ''SSI ratio'' which is the percent of patient days for beneficiaries who are eligible for Medicare Part A and SSI and (2) the ''Medicaid fraction'' which is the percent of patient days for patients who are eligible for Medicaid but not Medicare. Once a hospital qualifies for this DSH payment, CMS also determines a hospital's payment adjustment; Form Numbers: CMS–R–194 (OMB #: 0938–0691; *Frequency:* Reporting—Occasionally; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 800; *Total Annual Responses:* 800; *Total Annual Hours:* 400. (For policy questions regarding this collection contact JoAnn Cerne at 410–786–4530. For all other issues call 410–786–1326.)

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Integrity Program Organizational Conflict of Interest Disclosure Certificate and Supporting Regulations at 42 CFR 421.300–421.316; *Use:* Section 1893(d)(1) of the Social Security Act requires CMS to establish a process for identifying, evaluating, and resolving conflicts of interest. CMS proposed a process in Section 421.310 to mandate submission of pertinent information regarding conflicts of interest. The entities providing the information will be organizations that have been awarded, or seek award of, a Medicare Integrity Program contract. CMS needs this information to assess whether contractors who perform, or who seek to perform, Medicare Integrity Program functions, such as medical review, fraud review or cost audits, have organizational conflicts of interest and whether any conflicts have been resolved. *Form Number:* CMS–R–232 (OMB #: 0938–0723); *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 11; *Total Annual Responses:* 44; Total Annual Hours: 2,200. (For policy questions regarding this collection contact Joe Strazzire at 410–786–2775. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* Revision of a currently approved Collection; *Title of Information Collection:* Home Health Advance Beneficiary Notice (HHABN); *Use:* Home health agencies (HHAs) are required to provide written notice to Medicare beneficiaries under various circumstances involving the initiation, reduction, or termination of services. The vehicle used in these situations is the Home Health Advance Beneficiary Notice (HHABN). The notice is designed to ensure that beneficiaries receive complete and useful information regarding potential financial liability or any changes made to their plan of care (POC) to enable them to make informed consumer decisions. The notice must provide clear and accurate information about the specified services and, when applicable, the cost of services when Medicare denial of payment is expected by the HHA. *Form Number:* CMS–R–296 (OMB #: 0938–0781); *Frequency:* Reporting—Hourly, Daily, Weekly, Monthly, Yearly, Quarterly, Semi-annually, Biennially, Once and Occasionally; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 9024; *Total Annual Responses:* 12,349,787; *Total Annual Hours:* 1,028,737. (For policy questions regarding this collection contact Evelyn Blaemire at 410–786–1803. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by July 14, 2009:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number (CMS–10283), Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 7, 2009.

Michelle Shortt,

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

[FR Doc. E9–11422 Filed 5–14–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10237 and 10214, and CMS–10171]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The

necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Advantage Applications—Part C and regulations under 42 CFR 422 subpart K; *Use:* The Balanced Budget Act of 1997 established a new ''Part C'' in the Medicare statute Social Security Act (the Act), which provided for a Medicare+Choice (M+C) program. Under section 1851 of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for most individuals with end-stage renal disease (ESRD), could elect to receive benefits either through the Original Medicare Program or an M+C plan.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted on December 8, 2003. The MMA established the Medicare Prescription Drug Benefit Program (Part D) and made revisions to the provisions of Medicare Part C, governing what is now called the Medicare Advantage (MA) program (formerly Medicare+Choice).

Coverage for the prescription drug benefit is provided through contracted prescription drug plans or through Medicare Advantage (MA) plans that offer integrated prescription drug and health care coverage (MA–PD plans). Cost plans that are required under section 1876 of the Social Security Act, and Employer Group Waiver Plans (EGWP) may also provide a Part D benefit. Organizations wishing to provide services under the MA and MA–PD plans must complete an application, negotiate rates and receive final approval from CMS. Certain existing MA plans may also expand their contracted area by completing the Service Area Expansion (SAE) application. *Form Number:* CMS–10237 and 10214 (OMB# 0938–0935); *Frequency:* Yearly; *Affected Public:* Private Sector; *Number of Respondents:* 267; *Total Annual Responses:* 267; *Total Annual Hours:* 6,490. (For policy questions regarding this collection contact Betty Burrier at 410–786–4649. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Coordination of Benefits between Part D Plans and Other Prescription Coverage Providers; *Use:* Section 1860D–23 and 1860D–24 of the Social Security Act requires the Secretary to establish requirements for prescription drug plans to ensure the effective coordination between Part D plans, State pharmaceutical Assistance programs and other payers. This collection request will assist CMS, Part D plans and other payers with coordination of prescription drug benefits at the point-of-sale and tracking of the beneficiary's True out-of-pocket (TrOOP) expenditures using the TrOOP facilitator. This information will be used by Part D plans, other health insurers or payers, pharmacies and CMS to coordinate prescription drug benefits provided to the Medicare beneficiary. Beginning in CY 2009, CMS, via the TrOOP facilitation contractor, will automate the transfer of beneficiary coverage information when a beneficiary changes plans. *Form Number:* CMS–10171 (OMB# 0938–0978); *Frequency:* Hourly, yearly and occasionally; *Affected Public:* Business or other for-profits; *Number of Respondents:* 56,988; *Total Annual Responses:* 1,139,760; *Total Annual Hours:* 1,125,883. (For policy questions regarding this collection contact Christine Hinds at 410–786–4578. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* 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.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on June 15, 2009.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, E-mail: *OIRA_submission@omb.eop.gov.*

Dated: *May 7, 2009.*

Michelle Shortt,

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

[FR Doc. E9–11424 Filed 5–14–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Grant Application Data Summary (GADS) Form.

OMB No.: 0970–0328.

Description: The Grant Application Data Summary (GADS) form collects information from applicants seeking grants from the Administration for Native Americans (ANA). Applicants complete the GADS form as part of their funding package. This standardized format allows ANA to evaluate applications for financial assistance and to determine the relative focus of the projects for which such assistance is requested. The data collected focuses on the specific ANA program area for which the applicant is applying. ANA awards annual grants in the following nine competitive areas: (1) Social & Economic Develop Strategies (SEDS); (2) Alaska SEDS; (3) Special Initiative: Family Preservation: Improving the Well-Being of Children Planning; (4) Special Initiative: Family Preservation: Improving the Well-Being of Children Implementation; (5) Native Language Preservation & Maintenance Assessment; (6) Native Language Preservation & Maintenance Planning; (7) Native Language Preservation & Maintenance Implementation; (8) Native Language Preservation & Maintenance Immersion; (9) Environmental Regulatory Enhancement.

Respondents: Federally Recognized Indian Tribes, Tribal Governments, Native American Non-profits, Tribal Colleges and Universities.