states to inform their Medicaid coverage decisions.

HHS should continue to provide states with grants that encourage the coverage, adoption and provision of genetic services that have a sound evidence base.

6. In many cases, payment rates for genetic tests are lower than the actual cost of performing the test. Until the fee schedule can be reconsidered in a comprehensive way, the Secretary should direct CMS to address variations in payment rates for the genetic test Current Procedural Terminology (CPT) codes through its inherent reasonableness authority.

7. Genetic counseling is a critically important component of the appropriate use and integration of genetic tests and services. As such, SACGHS recommends the following:

- Qualified health providers should be allowed to bill directly for genetic counseling services. The Secretary should expeditiously identify an appropriate mechanism for determining the credentials and criteria needed for a health provider to be deemed qualified to provide genetic counseling services and eligible to bill directly for them.
- The Secretary should direct government programs to reimburse prolonged service codes when determined to be reasonable and necessary.
- HHS, with input from the various providers of genetic counseling services, should assess the adequacy of existing CPT Evaluation & Management (E&M) codes and their associated relative values with respect to genetic counseling services. Any inadequacies identified should be addressed as deemed appropriate.
- CMS should deem all non-physician health providers who are currently permitted to bill directly any health plan—public or private—eligible for a National Provider Identifier.
- The Secretary should direct CMS to allow non-physician health professionals who are qualified to provide genetic counseling services and who currently bill incident to a physician to utilize the full range of CPT E&M codes available for genetic counseling services.

8. Since providers act as intermediaries between health plans and plan members and thus have an important role in ensuring genetic tests and services are provided appropriately, there is a need to support the ongoing training and continued education of health providers in genetics and genomics. SACGHS's recommendations to the Secretary in 2004 included the following: the Secretary should develop a plan for HHS agencies to work collaboratively with state, federal and private organizations to support the development, cataloguing and dissemination of case studies and practice models that demonstrate the current relevance of genetics and genomics; and the Secretary should strive to incorporate genetics and genomics into relevant initiatives of HHS, including the National Health Information Infrastructure.

9. Reliable and trustworthy information about family history, genetics and genetic technologies should be developed and made more widely available through the internet and other mechanisms that allow patients and consumers to evaluate health plan benefits and health providers so that they may make the most appropriate and most financially responsible decisions for themselves and their families.

The Secretary should leverage HHS resources to develop and make widely available reliable and trustworthy information about genetics and genetic technologies to guide and promote informed decision making by healthcare consumers and providers. Such information should be made available though federal government Web sites and other appropriate mechanisms.

The full report is available electronically at *http://www4.od.nih.gov/oba/sacghs/public_comments.htm*. A paper or electronic copy also can be requested by calling the NIH Office of Biotechnology Activities at 301–496–9838– or by e-mailing Suzanne Goodwin at *goodwins@od.nih.gov*.

SACGHS is requesting comments on these recommendations and the overall content of the draft report. Public comments received by May 6, 2005, will be considered by SACGHS in preparing the final report. The report and the public comments will be discussed at SACGHS's next meeting on June 15–16, 2005, in Bethesda, MD. Comments also will be available for public inspection at the NIH Office of Biotechnology Activities Monday through Friday between the hours of 8:30 a.m. and 5 p.m.

Dated: March 28, 2005.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 05–6614 Filed 4–1–05; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Preventing Sexual and Intimate Partner Violence Within Racial/Ethnic Minority Communities

Announcement Type: New.

Funding Opportunity Number: RFA 05043.

Catalog of Federal Domestic Assistance Number: 93.136.

Key Dates: Letter of Intent Deadline: May 4, 2005.

Application Deadline: May 19, 2005.

I. Funding Opportunity Description

Authority: This program is authorized under section 391(a) of the Public Health Service Act (PHS Act), 42 U.S.C. 280b(a), section 393 of the PHS Act, 42 U.S.C. 280b–1a.

Background

The National Violence Against Women Survey (NVAWS) reports that approximately 1.5 million women are raped and/or physically assaulted by an intimate partner each year. Violence against women is a significant public health and criminal justice concern which disproportionately affects marginalized groups such as racial and ethnic minorities. This study further reports the racial and ethnic differences in the lifetime rates of rape, for example American Indian/Alaska Native women were identified as having almost twice the rate of African American or White women. Specifically, American Indian/Alaska Native women (34 percent) were significantly more likely to report that they were raped than African American women (19 percent) or White women (18 percent). The survey also found that women who identified themselves as Hispanic (14.6 percent) were significantly less likely to report they had ever been raped than women who identified themselves as non-Hispanic (18.4 percent). Additionally, American Indian/Alaska Native women (30.7 percent) were most likely to report Intimate Partner Violence, and Asian/Pacific Islander women (12.8 percent) were least likely to report Intimate Partner Violence. Other racial differences illustrate that close to one-third of African American women experience intimate partner violence in their lifetimes compared with one-fourth of White women. Furthermore, when you consider the rates for the most severe form of intimate partner violence, which is homicide, African American women (3.55) are three times as likely than White women (1.11) to die

as a result of intimate partner violence (CDC, 2001). There was little difference found in Hispanic (21.2 percent) and non-Hispanic women's (22.1 percent) reports of intimate partner violence.

More women than men experience intimate partner violence. According to the NVAWS, one out of four U.S. women has been physically assaulted or raped by an intimate partner and 1 out of every 14 U.S. men reported such an experience (Tjaden & Thoennes, 2000). Although women exhibit violent behavior in relationships with men and violence is also sometimes found in same sex partnerships, the overwhelming burden of intimate partner violence is experienced by women at the hands of men. Studies have consistently shown that in the case of female victims of sexual abuse, over 90 percent of the perpetrators are men (World Report on Violence and Health, 2002). Also, data from the NVAWS shows that 91.9 percent of the women reported that they were physically assaulted by a male (Tjaden & Thoennes, 2000). Therefore, there is a great need to work with men and boys as community leaders and change agents to prevent sexual violence/intimate partner violence (SV/IPV). As previously indicated, research suggests that racial/ethnic minorities bear a greater potential risk of victimization.

Purpose: The purpose of this program announcement is to integrate prevention principles, concepts and practices into racial/ethnic minority community efforts to address sexual and intimate partner violence. This program is intended to assist racial/ethnic minority communities to assess and prevent sexual and intimate partner violence. An emphasis will be placed on building capacity to work with men and boys in a culturally appropriate manner to prevent these forms of violence before they occur. The outcomes of interest will be achieved through four key processes: collaboration, planning, implementation, and evaluation. This program addresses the ''Healthy People 2010'' focus area(s) of Injury and Violence Prevention.

For the purposes of this program announcement the following definitions apply:

Sexual Violence (SV) includes a wide range of acts that occur in a variety of settings. There are four types of sexual violence (Basile & Saltzman, 2002): (1) A completed sex act without the victim's consent, or involving a victim who is unable to provide consent or refuse. A sex act is defined as contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object. (2) An attempted (but not completed) sex act without the victim's consent, or involving a victim who is unable to provide consent or refuse. (3) Abusive sexual contact including intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse. (4) Non-contact sexual abuse including voyeurism; intentional exposure of an individual to exhibitionism; pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse.

Intimate Partner Violence (IPV) is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Intimate partners represent various types of relationships and may be heterosexual or of the same sex. Some of the common terms used to describe intimate partner violence are domestic abuse, spouse abuse, domestic violence, courtship violence, battering, marital rape, and date rape (Saltzman, *et al.* 1999).

Primary Prevention—Individual, relationship or family, and/or community level strategies, policies and actions that prevent violence from initially occurring, including risk reduction. Primary prevention efforts work to modify and/or entirely eliminate the event, conditions, situations, or exposure to influences (risk factors) that result in the initiation of violence and associated injuries, disabilities, and deaths. Additionally, prevention efforts seek to identify and enhance protective factors that may prevent violence not only in at-risk populations but also in the community at large.

Racial/Ethnic Minority Communities—For the purpose of this program announcement, racial minorities are African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander. Ethnicity refers to Hispanic populations. Racial/ethnic minority communities are identified as experiencing a higher incidence and prevalence of SV/IPV as compared to the national average.

Measurable outcomes of the program will be in alignment with the following performance goal for the National Center for Injury Prevention and Control (NCIPC): Goal 1—Increase the capacity of injury prevention and control programs to address prevention of injuries and violence. This announcement is only for non-research activities supported by the Centers for Disease Control and Prevention. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address: *http://www.cdc.gov/od/ads/opspoll1.htm.*

Activities

Awardee activities for this program are as follows:

1. Conduct:

- An assessment of existing data that describes the known risk and protective factors related to the perpetration of SV/IPV within racial/ethnic minority populations.
- An analysis of existing program inventories directed at identifying program models and efforts to involve men and boys in ending SV/IPV and to determine the extent to which such efforts are reaching and/or applicable to working within racial/ethnic minority communities.
- An assessment of Baseline Knowledge, Attitudes, Beliefs and Behaviors (KABB) related to the prevention of SV/IPV. Examples can include men and boys knowledge, attitudes, beliefs or behavior around bystander action in relation to individual behavior and personal responsibility; assets or barriers at the community level; characteristics of community norms related to SV/IPV.

2. Create a leadership consortium. The leadership consortium must include participation from the recipient agency, and a minimum of four other agencies/organizations. The five organizations/agencies must represent and bring together a focus and understanding within the following areas of expertise:

- Sexual violence and intimate partner violence, including risk reduction and other public health approaches to preventing SV/IPV.
- Community leaders.
- Effective strategies to engage men and boys in preventing SV/IPV.
- Public health.
- Program evaluation.

3. Create an advisory committee that includes public and private partners that can facilitate reaching men and boys and other partners. The applicant should distinguish the function of the

advisory committee from those of the leadership consortium.

4. Participate in a cross-site evaluation.

5. Develop or adapt a culturally relevant program model that engages men and boys in the prevention of SV/IPV. The awardee should take into consideration relevance and community salience and existing program models identified through the analysis of existing program inventories.

6. Deliver, test and evaluate this program model in at least one and no more than three communities. This program model should include efforts addressing multiple system levels of prevention (at least 2, individual, relationship, and/or, community). *Note:* Five to ten percent of the Awardee's budget should be allocated to support the evaluation component of this project (*e.g.* staff time, travel, subject matter expert speaker, data collection).

7. Develop and implement a comprehensive evaluation plan that supports:

• Baseline and follow-up assessments and the formative work necessary to develop and test the program model

• A logic model to support building capacity to work with men and boys in a culturally appropriate manner to prevent SV/IPV before they occur.

• Data collection required to assess the capacity building measures and impact of this program model

Activities to build capacity within Awardee's Organization:

• Participate in training and technical assistance activities and opportunities directly related to this program announcement provided by CDC and training and technical assistance activities and opportunities indirectly related to this program announcement (*i.e.* UNC PREVENT) where appropriate and feasible.

• Institutionalize prevention principles, concepts and practices within the recipient organization beyond the knowledge and skills of the funded program staff.

• Establish a two-way process for systems to monitor and provide feedback to and from racial/ethnic minority communities.

• Compile and disseminate program results, including but not limited to dissemination to other organizations that serve racial/ethnic minority communities and relevant CDC programs (Rape Prevention and Education RPE), Domestic Violence Prevention Enhancements Through Leadership and Alliances (DELTA), Enhancing State Capacity to Address Child and Adolescent Health Through Violence Prevention (ESCAPe).

Awardee activities to build capacity in racial/ethnic minority communities (in at least one and not more than three):

• Provide primary prevention-focused training (including risk reduction), technical assistance and funding. The awardee should establish and describe relevant selection criteria for the determination of these communities. Primary prevention-focused training and technical assistance for programs on working with men and boys to prevent SV/IPV should meet the definition of prevention principles, concepts and practices.

• Provide training and technical assistance to communities for programs on working with men and boys on the concepts of SV/IPV prevention including risk reduction, individual behavior change, community organizing, strategic planning, program development implementation and evaluation.

• Support and provide assistance to communities on the selected program model. Monitor the activities of the community to ensure that the model program is implemented in a comprehensive manner and with fidelity to the tested model.

• Assist communities in the development of an evaluation plan and monitor the extent to which this plan is implemented.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities for this program are as follows:

1. Participate in the translation of prevention principles, concepts and practices into prevention-focused activities, strategies, and policies that can be integrated into the program model.

2. Provide guidance on how to identify an evaluation contractor and approving the hire of applicant's evaluation contractor.

3. Approve the staff and contractors funded through the program.

4. Provide support and assistance in the evaluation of the program model to be implemented within 1–3 communities (see Awardee Activity #5).

5. Facilitate and provide technical assistance for the cross-site evaluation.

6. Coordinate capacity-building prevention-focused training and technical assistance for the grantee.

7. Provide assistance in the management and technical performance of the implementation of prevention principles, concepts, practices, leadership, activities, and strategies.

8. Arrange for information sharing with other CDC grantees including but not limited to DELTA, RPE, and ESCAPe.

9. Share new evaluation/research information.

II. Award Information

Type of Award: Cooperative Agreement. CDC involvement in this program is listed in the Activities Section above.

Fiscal Year Funds: 2005.

Approximate Total Funding: $300,000.

Approximate Number of Awards: Two.

Approximate Average Award: $150,000. (This amount is for the first 12-month budget period, and includes both direct and indirect costs.)

Floor of Award Range: $150,000 (CDC will not make an award smaller than the floor amount).

Ceiling of Award Range: $150,000. (This ceiling is for the first 12-month budget period. CDC will not make an award for larger than the ceiling amount.)

Anticipated Award Date: September 29, 2005.

Budget Period Length: 12 months.

Project Period Length: Three years with a possibility for five years total. (An initial three-year project period is specified with the anticipation of an additional two years with year four and five contingent on the accomplishment of very specific outcomes in years one through three.)

Milestones and success necessary to continue into Years four and five.

The awardee has developed and implemented an inventory and series of KABB assessments that address the following:

• The presence or absence of efforts that are directed at engaging men and boys in ending SV/IPV.

• The individual, organizational and community level indicators that represent assets or barriers to implementing prevention strategies.

• The awardee has developed a leadership consortium comprised of adequate representation as outlined in the program announcement and has implemented a feedback mechanism that assesses the contribution and role of member organizations.

• The awardee has developed or modified an advisory committee comprised of adequate representation as outlined in the program announcement and has implemented a feedback mechanism that assesses the contribution and role of each member organization.

• The awardee has developed and tested (formative) a culturally relevant program model for working with men and boys in the prevention of SV/IPV.

• The awardee has developed a program logic model that specifies short term or intermediate markers (KABB, community capacity measures, *etc.*).

• The awardee has developed selection criteria to be used to objectively assess the sites being considered for the implementation of the program model.

• Implementation of the program model has been initiated in no more than three program sites.

• An evaluation plan has been developed, measures identified or developed and the baseline data collected.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the applicant (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

III.1. Eligible Applicants

This program is directed to:

• Public and private nonprofit organizations with at least three years experience in addressing violence against women or women's health issues at a regional or national level. They must also demonstrate that 85 percent of the population served within the last three years represent one racial/ethnic minority population.

—Or—

• Regional or national organizations representing consortia or coalitions of American Indian communities or Alaska Native villages. Examples of such organizations would include area or regional health boards, inter-tribal councils, tribal chairmen's health boards.

III.2. Cost Sharing or Matching

Matching funds are not required for this program.

III.3. Other

If you request a funding amount greater than the ceiling of the award range, your application will be considered non-responsive, and will not be entered into the review process. You will be notified that your application did not meet the submission requirements.

Special Requirements

If your application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. You will be notified that your application did not meet submission requirements.

• Late applications will be considered non-responsive. See section ''IV.3. Submission Dates and Times'' for more information on deadlines.

• The application is required to clearly specify the one racial/ethnic community to be served.

• Non-profit 501(c)(3) status—provide copy of IRS determination letter with LOI and application.

• **Note:** Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

IV. Application and Submission Information

IV.1. Address To Request Application Package

To apply for this funding opportunity use application form PHS 5161–1.

Electronic Submission

CDC strongly encourages you to submit your application electronically by utilizing the forms and instructions posted for this announcement on *http://www.Grants.gov,* the official Federal agency wide E-grant Web site. Only applicants who apply online are permitted to forego paper copy submission of all application forms.

Paper Submission

Application forms and instructions are available on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm.*

Pre-Application Conference Call

For interested applicants, one pre-application technical assistance call will be conducted. The call will be held for one hour on April 19, 2005, from 2–3 p.m. e.s.t. Please e-mail Rebeca Lee-Pethel at *rlee-pethel@cdc.gov* by April 11, 2005, to request the conference call number and code. The conference call number and code will be provided via e-mail. The conference call name is Preventing Sexual and Intimate Partner Violence within Racial/Ethnic Minority Communities.

IV.2. Content and Form of Submission

Letter of Intent (LOI): Your LOI must be written in the following format:

• Maximum number of pages: Two.
• Font size: 12-point unreduced.
• Double spaced.
• Paper size: 8.5 by 11 inches.
• Page margin size: One inch.
• Printed only on one side of page.
• Written in plain language, avoid jargon.

Your LOI must contain the following information:

• Name of organization.
• Stated intent to submit an application for the Preventing Sexual and Intimate Partner Violence within Racial/Ethnic Minority Communities and clearly specifying the one racial/ethnic community to be served.
• Signature of Program Official and Financial Officer.
• IRS 501(c)(3) determination letter as page 2.

Application

Electronic Submission: You may submit your application electronically at: *http://www.grants.gov.* Applications completed online through Grants.gov are considered formally submitted when the applicant organization's Authorizing Official electronically submits the application to *http://www.grants.gov.* Electronic applications will be considered as having met the deadline if the application has been submitted electronically by the applicant organization's Authorizing Official to Grants.gov on or before the deadline date and time.

It is strongly recommended that you submit your grant application using Microsoft Office products (*e.g.*, Microsoft Word, Microsoft Excel, *etc.*). If you do not have access to Microsoft Office products, you may submit a PDF file. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

CDC recommends that you submit your application to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV.3. of the grant announcement. The paper submission must be clearly marked: ''BACK-UP FOR ELECTRONIC SUBMISSION.'' The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

Paper Submission: If you plan to submit your application by hard copy, submit the original and two hard copies of your application by mail or express delivery service. Refer to section IV.6. Other Submission Requirements for submission address.

You must submit a project narrative with your application forms. The

narrative must be submitted in the following format:

- Maximum number of pages: 25—If your narrative exceeds the page limit, only the first 25 pages will be reviewed.
- Font size: 12 point unreduced.
- Double spaced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Printed only on one side of page.
- Held together only by rubber bands or metal clips; not bound in any other way.

Your narrative should address activities to be conducted over the entire 3 year project period, and must include the following items in the order listed:

1. Applicant Organization History, Description and Capacity.
2. Applicant's Plan for Implementing This Cooperative Agreement.
3. Collaboration.
4. Evaluation.
5. Applicant's Management and Staffing.
6. Measures of Effectiveness.
7. Budget Justification (does not count towards 25 page limit).

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit (do not use staples). This additional information includes:

1. Curriculum Vitae.
2. Job Descriptions.
3. Resumes.
4. Organizational Charts.
5. Letters of Support, *etc.*
6. Logic Model.

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *www.dunandbradstreet.com* or call 1–866–705–5711.

For more information, see the CDC Web site at: *http://www.cdc.gov/od/pgo/funding/pubcommt.htm.* If your application form does not have a DUNS number field, please write your DUNS number at the top of the first page of your application, and/or include your DUNS number in your application cover letter.

Additional requirements that may require you to submit additional documentation with your application are listed in section ''VI.2. Administrative and National Policy Requirements.''

IV.3. Submission Dates and Times

LOI Deadline Date: May 4, 2005. CDC requests that you submit a LOI if you intend to apply for this program. Although the LOI is not required, not binding, and does not enter into review of your subsequent application, the LOI will be used to gauged the level of interest in this program, and to allow CDC to plan the application review.

Application Deadline Date: May 19, 2005.

Explanation of Deadlines: LOIs and Applications must be received in the CDC Procurement and Grants Office by 4 p.m. Eastern Time on the deadline date. If you submit your LOI or application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery by the closing date and time. If CDC receives your submission after closing due to: (1) Carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, you will be given the opportunity to submit documentation of the carriers guarantee. If the documentation verifies a carrier problem, CDC will consider the submission as having been received by the deadline.

This announcement is the definitive guide on LOI and application content, submission address, and deadline. It supersedes information provided in the application instructions. If your submission does not meet the deadline above, it will not be eligible for review, and will be discarded. You will be notified that you did not meet the submission requirements.

Electronic Submission: If you submit your application electronically with Grants.gov, your application will be electronically time/date stamped which will serve as receipt of submission. In turn, you will receive an e-mail notice of receipt when CDC receives the application. All electronic applications must be submitted by 4 p.m. Eastern Time on the application due date.

Paper Submission: CDC will *not* notify you upon receipt of your paper submission. If you have a question about the receipt of your LOI or application, first contact your courier. If you still have a question, contact the PGO–TIM staff at: 770–488–2700. Before calling, please wait two to three days after the submission deadline. This will allow time for submissions to be processed and logged.

IV.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

IV.5. Funding restrictions

Restrictions, which must be taken into account while writing your budget, are as follows:

- Funds may not be used for research.
- Reimbursement of pre-award costs is not allowed.
- Budgets for each program year should include travel costs for a representative from each of the organizations on the leadership consortium and the applicant's evaluation contractor to attend a 3-day planning and training meeting in Atlanta, Georgia with CDC staff.
- Applicants are required, at a minimum, to have the equivalent of one full time employee assigned to the programmatic activities.
- Funding may not be used for construction.
- Funding may be used to purchase computer equipment and software and internet connection equipment and software.
- Funding may not be used to provide direct services to victims or perpetrators of SV/IPV.
- Funding will not be given to two applicants representing the same racial/ethnic minority population. It is necessary for the project to ensure that funding will go towards more than one particular racial or ethnic minority.

If you are requesting indirect costs in your budget, you must include a copy of your indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. Guidance for completing your budget can be found on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/funding/budgetguide.htm.*

IV.6. Other Submission Requirements

LOI Submission Address: Submit your LOI by express mail, or delivery service to: Rebeca Lee-Pethel, Project Officer, National Center for Injury Prevention and Control, Koger/Vanderbilt Building, 2939 Flowers Road, Atlanta, GA 30341, Telephone: 770–488–1224, Fax: 770–488–1360, E-mail: *rlee-pethel@cdc.gov.*

Application Submission Address

Electronic Submission: CDC strongly encourages applicants to submit electronically at: *http://www.grants.gov.* You will be able to download a copy of the application package from *http://www.grants.gov*, complete it offline, and then upload and submit the application via the Grants.gov site. E-mail

submissions will not be accepted. If you are having technical difficulties in Grants.gov they can be reached by e-mail at *support@grants.gov* or by phone at 1–800–518–4726 (1–800–518–GRANTS). The Customer Support Center is open from 7 a.m. to 9 p.m. eastern time, Monday through Friday.

Paper Submission: If you chose to submit a paper application, submit the original and two hard copies of your application by mail or express delivery service to: Technical Information Management—RFA 05043, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

V. Application Review Information

V.1. Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives within the Purpose and Awardee Activities sections of the cooperative agreement. Measures effectiveness must relate to the performance goals stated in the ''Purpose'' section of this announcement: Increase the capacity of injury prevention and control programs to address the prevention of injuries and violence. Measures must be objective and quantitative, and must measure the intended outcome. Applicants are expected to develop four measures of effectiveness, one for each level of capacity-building: collaboration, planning, implementation and evaluation. Measures of effectiveness will be an element of evaluation.

Your application will be evaluated against the following criteria:

1. Plans for Development and Implementation (30 Points)

a. Does the applicant adequately describe the problem of SV/IPV within the population they serve? Is this supported by government reports and credible research sources?

b. Does the applicant describe plans for conducting an assessment of existing data that describes known risk and protective factors for SV/IPV within one specific racial/ethnic community?

c. Does the applicant describe plans for conducting an analysis of existing prevention program inventories?

d. Does the applicant describe plans for conducting a baseline assessment of Knowledge, Attitudes, Beliefs and Behaviors (KABB) and community assets and barriers related to the prevention of SV/IPV?

e. Does the applicant describe plans for selecting the one to three racial/ethnic communities for technical assistance and funding?

f. Does the applicant describe plans for developing the leadership consortium?

g. Does the applicant describe plans for developing an advisory committee?

h. Does the applicant include plans for working with CDC, the advisory committee and leadership consortium to reach consensus and uniformity in selecting core measures, tools and processes for capacity building measures and the program model development and implementation?

i. Does the applicant demonstrate a clear plan for effectively involving various stakeholders (state, local, regional, and/or racial/ethnic minority communities) in the assessment and planning processes?

j. Is the plan adequate to carry out the proposed objectives? Are the proposed methods feasible and to what extent will they accomplish the program goals? Are the goals and objectives specific, measurable, achievable, realistic and time-specific? Are roles and responsibilities clearly identified?

k. Does the applicant describe a plan to identify model programs or resources that are directed to work with men and boys and a plan for testing these messages, strategies and approaches with approaches within one racial/ethnic minority community?

2. Applicant Organization History, Description and Capacity (25 Points)

a. Does the applicant demonstrate its history and capacity in providing leadership and guidance to racial/ethnic minority community efforts, including a clear description of its linkages with and role in support for the racial/ethnic minority community addressed in this proposal? Does the applicant demonstrate 85 percent of the population they serve are of the racial/ethnic minority group proposed in this application? Does the applicant demonstrate experience addressing violence against women or women's health issues (minimum of three years)?

b. Does the applicant demonstrate its experience as well as its current ability to provide leadership at a regional or national organizational level?

c. Does the applicant demonstrate its experience and a description of its current capacity to provide leadership in involving other agencies?

d. Does the applicant demonstrate its organizational experience and current capacity to provide training and technical assistance?

e. Does the applicant demonstrate experience in developing and implementing an evaluation plan? Does the applicant have experience using data to determine organizational priorities?

3. Collaboration (20 Points)

a. Does the applicant describe the composition, role and involvement of the leadership consortium, and identify or propose participants representing a broad range of disciplines that include expertise in SV/IPV, Tribal or community leaders and/or elders, prevention and public health approaches to preventing SV/IPV, and evaluation?

b. Does the applicant include resource agreements between leadership consortium agencies (this can be included as direct contracts or in-kind reflected within the proposed budget)? Does the applicant include memorandum of agreement or contractual agreements with the leadership consortium organizations? Does the applicant describe how the partner organizations will be involved in the data identification, collection, *etc*?

c. Does the applicant describe the composition, role and involvement of the advisory committee, and identify or propose participants representing public and private partners that can facilitate reaching men and boys and other partners?

d. Does the applicant describe the roles and responsibilities for both the advisory committee and leadership consortium? Does the applicant describe how these two groups will work together?

e. Does the applicant demonstrate a willingness to collaborate with CDC on all aspects of this project? Does the applicant demonstrate a willingness to collaborate with relevant CDC awardees and partners?

f. Does the applicant demonstrate experience and leadership in working with racial/ethnic minority communities by also including letters of support and/or memoranda of agreement from organizations, research and/or academic experts/institutions, and other agencies and organizations, including public health agencies and organizations that work with racial/ethnic minority communities and agencies working with men and boys?

4. Evaluation (15 Points)

a. Does the applicant provide a draft logic model that supports building capacity to work with men and boys in a culturally appropriate manner to prevent SV/IPV before they occur and represents the program model being delivered? Does this draft logic model identify outcome measures at a minimum of 2 levels and include

individual behavior and personal responsibility? For assistance on how to design a logic model, access CDC's Web site: *http://www.cdc.gov/nccdphp/dnpa/physical/handbook/step2.htm*.

b. Does the applicant demonstrate a willingness to collaborate with CDC evaluation experts?

c. Does the applicant allocate 5–10 percent of the budget to support the evaluation component of this project?

5. Staffing (10 Points)

a. Does the applicant describe the responsibilities of individual staff members, including their level of effort and allocation of time? Does the applicant identify at least one full time employee to manage this project?

b. Does the applicant describe project staff and their relevant skills and expertise working with racial/ethnic minority communities and for their assigned tasks relative to this announcement? Are Curriculum Vitas and job descriptions provided?

c. Does the applicant include an organizational chart?

6. Measures of Effectiveness (Not Scored)

7. Proposed Budget and Justification (Not Scored)

V.2. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff, and for responsiveness by the National Center for Injury Prevention and Control (NCIPC). Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified that their application did not meet submission requirements.

An objective review panel comprised of CDC employees will evaluate complete and responsive applications according to the criteria listed in the ''V.1. Criteria'' section above. In addition, the following factors may affect the funding decision:

- Maintaining geographic diversity.
- Ensuring that racial/ethnic minority communities are represented by funding two applicants which reflect racial/ethnic minority communities who experience a higher incidence and prevalence of SV/IPV as compared to the national average through adequate service experience and organizational representation.
- Ensuring that the two awardees are not representing the same racial/ethnic minority population.

CDC will provide justification for any decision to fund out of rank order.

V.3. Anticipated Announcement and Award Dates

Anticipated Announcement Date: September 1, 2005.

Anticipated Award Date: September 1, 2005.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Award (NOA) from the CDC Procurement and Grants Office. The NOA shall be the only binding, authorizing document between the applicant and CDC. The NOA will be signed by an authorized Grants Management Officer, and mailed to the applicant fiscal officer identified in the application. Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

45 CFR Part 74 and Part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: *http://www.access.gpo.gov/nara/cfr/cfr-table-search.html*.

An additional Certifications form from the PHS5161–1 application needs to be included in your Grants.gov electronic submission only. Refer to *http://www.cdc.gov/od/pgo/funding/PHS5161–1-Certificates.pdf*. Once the form is filled out attach it to your Grants.gov submission as Other Attachments Form.

The following additional requirements apply to this project:

- AR–9 Paperwork Reduction Act Requirements.
- AR–10 Smoke-Free Workplace Requirements.
- AR–11 Healthy People 2010.
- AR–12 Lobbying Restrictions.
- AR–13 Prohibition on Use of CDC Funds for Certain Gun Control Activities.
- AR–14 Accounting System Requirements.
- AR–15 Proof of Non-Profit Status.
- AR–16 Security Clearance Requirement.
- AR–25 Release and Sharing of Data.

Additional information on these requirements can be found on the CDC Web site at the following Internet address: *http://www.cdc.gov/od/pgo/funding/ARs.htm*.

VI.3. Reporting Requirements

You must provide CDC with an original, plus two hard copies of the following reports:

1. Interim progress report, due no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following elements:

a. Current Budget Period Activities Objectives (for first six months of budget period).

b. Current Budget Period Financial Progress.

c. New Budget Period Program Proposed Activity Objectives (provides updated logic models and narratives).

d. Budget.

e. Measures of Effectiveness.

f. Additional Requested Information.

2. Annual progress report, due 90 days after the end of the budget period.

a. Current Budget Period Activities Objectives (for second six months of budget period).

b. New Budget Period Program Proposed Activity Objectives (provides updated logic models and narratives).

c. Measures of Effectiveness.

d. Additional Requested Information.

3. Financial status report, due no more than 90 days after the end of the budget period.

4. Final financial and performance reports, no more than 90 days after the end of the project period.

These reports must be mailed to the Grants Management or Contract Specialist listed in the ''Agency Contacts'' section of this announcement.

VII. Agency Contacts

We encourage inquiries concerning this announcement. For general questions, contact: Technical Information Management Section, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2700.

For program technical assistance, contact: Rebeca Lee-Pethel, Project Officer, National Center for Injury Prevention and Control, 4770 Buford Highway, NE Mailstop K60, Atlanta, GA 30341, Telephone: 770–488–1224, Fax: 770–488–1360, E-mail: *rlee-pethel@cdc.gov*.

For financial, grants management, or budget assistance, contact: Brenda Hayes, Grants Management Specialist, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2741, Fax: 770/488–2670, E-mail: *BKH4@cdc.gov*.

VIII. Other Information

This and other CDC funding opportunity announcements can be found on the CDC Web site, Internet address: *http://www.cdc.gov*. Click on ''Funding'' then ''Grants and Cooperative Agreements.''

Dated: March 28, 2005.

William P. Nichols,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 05–6580 Filed 4–1–05; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

National Institute for Occupational Safety and Health Advisory Board on Radiation and Worker Health

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following committee meeting:

Name: Advisory Board on Radiation and Worker Health (ABRWH), National Institute for Occupational Safety and Health (NIOSH).

Place: Teleconference call will originate at the Centers for Disease Control and Prevention, National Institutes for Occupational Safety and Health, Atlanta, Georgia. Please see **SUPPLEMENTARY INFORMATION** for details on accessing the teleconference.

Status: Open to the public, teleconference access limited only by ports available.

Background: The ABRWH was established under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000 to advise the President, delegated to the Secretary of Health and Human Services (HHS), on a variety of policy and technical functions required to implement and effectively manage the new compensation program. Key functions of the Board include providing advice on the development of probability of causation guidelines which have been promulgated by HHS as a final rule, advice on methods of dose reconstruction which have also been promulgated by HHS as a final rule, advice on the scientific validity and quality of dose estimation and reconstruction efforts being performed for purposes of the compensation program, and advice on petitions to add classes of workers to the Special Exposure Cohort (SEC).

In December 2000 the President delegated responsibility for funding, staffing, and operating the Board to HHS, which subsequently delegated this authority to the CDC. NIOSH implements this responsibility for CDC. The charter was issued on August 3, 2001, and renewed on August 3, 2003.

Purpose: This board is charged with (a) providing advice to the Secretary, HHS on the development of guidelines under Executive Order 13179; (b) providing advice to the Secretary, HHS on the scientific validity and quality of dose reconstruction efforts performed for this Program; and (c) upon request by the Secretary, HHS, advise the Secretary on whether there is a class of employees at any Department of Energy facility who were exposed to radiation but for whom it is not feasible to estimate their radiation dose, and on whether there is reasonable likelihood that such radiation doses may have endangered the health of members of this class.

Matters to be Discussed: Agenda for this meeting will focus on Status of Activities concerning Iowa Army Ammunition Plant and Mallinckrodt Downtown Site; Special Exposure Cohort Task for SC&A, Inc.; and review of Draft Agenda for the upcoming meeting. The agenda is subject to change as priorities dictate. In the event an individual cannot attend, written comments may be submitted. Any written comments received will be provided at the meeting and should be submitted to the contact person below well in advance of the meeting.

Supplementary Information: This conference call is scheduled to begin at 1:30 p.m. eastern time. To access the teleconference you must dial 1–888–391–6569. You will need to provide the passcode 51897 to be connected to the call.

This notice is being published less than 15 days prior to the meeting due to the unexpected urgency of the topics that will be discussed.

Contact Person for More Information: Larry Elliott, Director of Office of Compensation, Analysis, and Support, NIOSH, CDC, 4676 Columbia Parkway, Cincinnati, Ohio 45226, telephone 513/533–6825, fax 513/533–6826.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: March 29, 2005.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 05–6576 Filed 4–1–05; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10140, CMS–460, CMS–R–65]

Agency Information Collection Activities: Proposed Collection; 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) 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 functions; (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:* New Collection; *Title of Information Collection:* Claims Error Rate Testing (CERT)/Electronic Medical Records Exploratory Survey; *Form No.:* CMS–10140 (OMB# 0938–NEW); *Use:* The Centers for Medicare and Medicaid Services (CMS) is using a private vendor to conduct market research to assess the value of electronic patient medical records relative to the Claims Error Rate Testing (CERT) program and determine what actions CMS can take to encourage the use of electronic records for the purpose of lowering the CERT error rate. The proposed effort will test the hypothesis that increased functionality of electronic records (meaning, greater connectivity and features), is associated with lower CERT error rates related to coding, non-response and incomplete documentation. The project is expected to assist CMS in identifying a strategy to improve the CERT claims error rate by developing an approach that would both facilitate and encourage the use of electronic patient medical records in the health care setting. This research focuses on physician practices, outpatient hospitals, durable medical equipment (DME) providers and skilled nursing facilities (SNFs) that have been