Business or other for-profits, and Individual and households; *Number of Respondents:* 6,400; *Total Annual Responses:* 6,400; *Total Annual Hours:* 1,472.

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 *September 15, 2008.* OMB Human Resources and Housing Branch, *Attention:* OMB Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, *Fax Number:* (202) 395–6974.

Dated: August 7, 2008.

Michelle Shortt,

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

[FR Doc. E8–18957 Filed 8–14–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–4040 and 4040SP, CMS–R–10, CMS–10130A and 10130B, and CMS–R–257]

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:* Extension of a currently approved collection; *Title of Information Collection:* Request for Enrollment in Supplementary Medical Insurance; *Use:* Section 1836 of the Social Security Act and 42 CFR 407.10 provide the eligibility requirements for enrollment in Supplementary Medical Insurance (Part B) for individuals age 65 and older who are not entitled to premium-free Hospital Insurance (Part A). The form CMS–4040 is used to establish entitlement to Part B by individuals ineligible for Part A under Title XVIII of the Social Security Act. *Form* Number: CMS–4040 and 4040SP (OMB# 0938–0245); *Frequency:* Once; *Affected Public:* Individuals and households; *Number of Respondents:* 10,000; *Total Annual Responses:* 10,000; *Total Annual Hours:* 2,500.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* BPD–718: Advance Directives (Medicare and Medicaid); *Use:* Steps have been taken at both the Federal and State level to afford greater opportunity for the individual to participate in decisions made concerning the medical treatment to be received by an adult patient in the event that the patient is unable to communicate to others a 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 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. Sections 4206 of OBRA '90 defined an advance directive as a written instruction recognized under State law relating to the provision of health care when an individual is incapacitated (those persons unable to communicate their wishes regarding medical treatment).

All states have enacted legislation defining a patient's right to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Participating hospitals, skilled nursing facilities/nursing facilities, home health agencies, providers of home health care, hospices, religious nonmedical health care institutions, and prepaid or eligible organizations (including Health Care Prepayment Plans (HCPPs) and Medicare Advantage Organizations (MAOs) such as Coordinated Care Plans, Demonstration Projects, Chronic Care Demonstration Projects, Program of All Inclusive Care for the Elderly, Private Fee for Service, and Medical Savings Accounts must provide written information, at explicit time frames, to all adult individuals about: (a) The right to accept or refuse medical or surgical treatments; (b) the right to formulate an advance directive; (c) a description of applicable State law (provided by the State); and (d) the provider's or organization's policies and procedures for implementing an advance directive. *Form Number:* CMS–R–10 (OMB# 0938–0610); *Frequency:* Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 35,484; *Total Annual Responses:* 19,870,000; *Total Annual Hours:* 927,550.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): ''Section 1011 Provider Payment Determination'' and ''Request for Section 1011 Hospital On-Call Payments to Physicians'' Forms; *Use*: Section 1011 of the MMA requires that the Secretary establish a process under which eligible providers (certain hospitals, physicians and ambulance providers) may request payment for (claim) their otherwise un-reimbursed costs of providing eligible services. The Secretary must make quarterly payments directly to such providers. The Secretary must also implement measures to ensure that inappropriate, excessive, or fraudulent payments are not made under Section 1011, including certification by providers of the accuracy of their requests for payment. The Section 1011 Provider Payment Determination and the Request for Section 1011 Hospital On-Call Payments to Physicians forms have been established to address the statutory requirements. *Form Number:* CMS–10130A and 10130B (OMB# 0938–0952); *Frequency:* Daily, Weekly,

Monthly, Quarterly and Yearly; *Affected Public:* Business or Other For-Profits and Not-for-Profit Institutions; *Number of Respondents:* 12,037; *Total Annual Responses:* 300,148; *Total Annual Hours:* 75,007.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Advantage & Part D Disenrollment Requests Collected Through 1–800–MEDICARE; *Use:* Section 4001 of the Balanced Budget Act of 1997 amended the Social Security Act to add Section 1851(c)(1), through which Medicare Advantage elections are made and changed. Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act amended the Social Security Act to include section 1860D–1(b)(1), through which Medicare Prescription Drug Plan enrollments are made and changed. The disenrollment process offered at 1–800–MEDICARE provides beneficiaries with the option of submitting a disenrollment request to a neutral third party, who then processes the disenrollment action as a change of enrollment.

The collection updates: 1. Continue to allow Medicare beneficiaries to disenroll from Medicare Advantage plans by calling CMS' toll-free call center; 2. Continue to allow Medicare beneficiaries enrolled in Medicare Prescription Drug (Part D) Plans to request disenrollment from Medicare Prescription Drug Plans, and 3. Retire the CMS–R–257 Medicare Advantage Disenrollment Form given limited (zero) requests for the paper form since 2005. The information collected in the disenrollment process will be used to update the Medicare beneficiary's Health Insurance Master Record System in order to disenroll the beneficiary from a Medicare Advantage managed care plan or a Medicare prescription drug plan on a timely basis. *Form Number:* CMS–R–257 (OMB# 0938–0741); *Frequency:* Occasionally; *Affected Public:* Individuals or households; *Number of Respondents:* 117,000; *Total Annual Responses:* 117,000; *Total Annual Hours:* 19,539.

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 *October 14, 2008:*

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, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: August 7, 2008.

Michelle Shortt,

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

[FR Doc. E8–18958 Filed 8–14–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Evaluation of the Improving Child Welfare Outcome through Systems of Care Grant Program.

OMB No.: 0970–0288.

Description: The 1994 Amendments to the Social Security Act (SSA) authorize the U.S. Department of Health and Human Services to review State child and family service programs to ensure conformance with the requirements in titles IV–B and IV–E of SSA. Under the Final Rule, which took effect March 25, 2000, States are assessed for substantial conformity with certain Federal requirements for child-welfare services. The Child and Family Service Reviews (CFSR), administered by the Children's Bureau, are designed to ensure conformity with Federal child-welfare requirements and, ultimately, to help States improve child welfare services and outcomes, specifically safety, permanency and well-being outcomes for child-welfare-involved children and their families. States determined not to have achieved substantial conformity in any of the areas assessed are required to develop and implement Program Improvement Plans (PIP) addressing the areas of nonconformity.

The Systems of Care grant cluster, from which these data are proposed to be collected, is designed to encourage public child-welfare agencies to address the issues identified in their State's CPSR. The data collected from these demonstration sites will allow the Children's Bureau to test whether this approach can help States reach the goals stated in their PIP and explore how child-welfare can benefit from being part of a system of care. Data will be collected via interviews, forms completed by project staff, surveys, focus groups and case-file reviews. Data also will be collected to determine the extent to which the Technical Assistance (TA) provided, brokered or contracted by the TA and Evaluation Center is meeting the needs of the grantees, and how.

Respondents: Systems of Care Project Directors (members of the Systems of Care collaborative may include representatives from mental health, juvenile justice, education, health, among others); child-welfare agency supervisors and caseworkers; partner agency caseworkers; and families who have been involved with the child-welfare system.

ANNUAL BURDEN ESTIMATES

Instrument	Affected public	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Stakeholder Survey	Individuals/Households	20	1	.5	10
	Private Sector	60	1	.5	30
	State/Local/Tribal	190	1	.5	95
Child-Welfare Agency Survey	State/Local/Tribal	600	1	1	600
Supervisor Interviews	State/Local/Tribal	90	1	1	90