[9] Staff will enter data on flexible funds expenditures into a Web-based application or will recode existing data on flexible funds expenditures to match the Flex Funds Data Dictionary format. Each community will use flexible funds expenditures on average for approximately one-quarter of the estimated 356 children/youth enrolled, suggesting a total of 89 children/youth will receive services from flexible funds per community. Thus, there will be data entered for 89 × 30 = 2,670 children/youth using the Flex Funds Data Dictionary.

[10] Assumes that three expenditures, on average, will be spent on each child/youth receiving flexible fund benefits.

[11] Staff will collect paper-based forms from agencies and enter them into a Web-based application or will extract data from agencies' existing data systems. Staff will recode data to match the Services and Costs Data Dictionary format. Service and costs records will be compiled for all 356 × 30 = 10,680 children/youth enrolled.

[12] Assumes that each child/youth will have 100 service episodes, on average, during his/her time in a system of care.

[13] This survey will be administered in 5 communities funded in 2006, 25 communities funded in 2005, 2 communities funded in 2000, and 20 communities funded in 1999. For each community, one respondent will be a caregiver and three respondents will be administrators/providers.

Written comments and recommendations concerning the proposed information collection should be sent by August 31, 2009 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 27, 2009.

Elaine Parry,

Director, Office of Program Services.

[FR Doc. E9–18315 Filed 7–30–09; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–43, CMS–1763, CMS–R–194 and CMS–R–296]

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:* Application for Hospital Insurance Benefits for Individuals with End Stage Renal Disease: *Use:* Effective July 1, 1973, individuals with End Stage Renal Disease (ESRD) became entitled to Medicare. Because this entitlement has a different set of requirements, the existing applications for Medicare were not sufficient to capture the information needed to determine Medicare entitlement under the ESRD provisions of the law. The Application for Hospital Insurance Benefits for Individuals with End Stage Renal Disease, was designed to capture all the information needed to make a Medicare entitlement determination; Form Numbers: CMS–43 (OMB#: 0938–0800; *Frequency:* Reporting—Once; Affected Public: Individuals or households; *Number of Respondents:* 60,000; *Total Annual Responses:* 60,000; *Total Annual Hours:* 25989. (For policy questions regarding this collection contact Naomi Rappaport at 410–786–2175. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Termination of Premium Hospital and/or Supplementary Medical Insurance: *Use:* The Social Security Act (the Act) allows a Medicare enrollee to voluntarily terminate Supplementary Medical Insurance (Part B) and/or the premium Hospital Insurance (premium-Part A) coverage by filing a written request with CMS or the Social Security Administration (SSA). The Act also stipulates when coverage will end based upon the date the request was filed. Because Medicare is recognized as a valuable protection against the high cost of medical and hospital bills, when an individual wishes to voluntarily terminate Part B and/or premium Part A, CMS and SSA requests the reason that an individual wishes to terminate coverage to ensure that the individual understands the ramifications of the decision. The Request for Termination of Premium Hospital and/or 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.)

3. *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.)

4. *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 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 August 31, 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: July 23, 2009.

Michelle Shortt,

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

[FR Doc. E9–18379 Filed 7–30–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10191]

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:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Parts C and D Universal Audit Guide; *Use:* Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and implementing regulations at 42 CFR Parts 422 and 423 Medicare Part D plan sponsors and Medicare Advantage organizations are required to comply with all Medicare Parts C and D program requirements. 42 CFR 422.502 describes CMS' regulatory authority to evaluate, through inspection or other means, Medicare Advantage Part C organizations. These records include books, contracts, medical records, patient care documentation and other records that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable. 42 CFR 423.503 states that CMS must oversee a Part D plan sponsor's continued compliance with the requirements for a Part D plan sponsor. § 423.514 states that the Part D plan sponsor must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, statistics regarding areas such as cost of operations, patterns of utilization availability, accessibility, and acceptability of services.

The explosive growth of these sponsoring organizations has forced CMS to update its current auditing strategy to ensure we continue to obtain meaningful audit results. As a result, CMS' audit strategy will reflect a move away from routine audits to more targeted, data-driven and risk-based audits. CMS will also focus on high-risk areas that have the greatest potential for beneficiary harm. The goal of the audits will be the earliest possible detection and correction of issues and improvement in quality and performance of Part D sponsors and Medicare Advantage organizations.

To accomplish these goals, we have combined all Part C and Part D audit elements into one universal guide which will also promote consistency, effectiveness and reduce financial and time burdens for both CMS and Medicare-contracting entities. Please refer to the crosswalk document for a list of changes. *Form Number:* CMS–10191 (OMB#: 0938–1000); *Frequency:* Reporting—Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 195; *Total Annual Responses:* 195; *Total Annual Hours:* 24,180. (For policy questions regarding this collection contact Laura Dash at 410–786–8623. 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 *September 29, 2009:*

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov*. Follow the