Dated: July 20, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–18146 Filed 7–23–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Guidance for Tribal TANF.

OMB No.: 0970–0157

Description: 42 U.S.C. 612 (Section 412 of the Social Security Act) requires each Indian Tribe that elects to administer and operate a Temporary Assistance for Needy Families (TANF) program to submit a TANF Tribal Plan. The TANF Tribal Plan is a mandatory statement submitted to the Secretary by the Indian Tribe, which consists of an outline of how the Indian Tribes TANF program will be administered and operated. It is used by the Secretary to determine whether the plan is approvable and to determine that the Indian Tribe is eligible to receive a TANF assistance grant. It is also made available to the public.

Respondents: Indian Tribes applying to operate a TANF program.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Request for State Data Needed to Determine the Amount of a Tribal Family Assistance Grant	20	1	68	1,360

Estimated Total Annual Burden Hours: 1,360.

Additional Information:

Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, *Attn:* ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. *E-mail address: infocollection@acf.hhs.gov.*

OMB Comment:

OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, *Fax:* 202–395–7285, *E-mail: OIRA_SUBMISSION@OMB.EOP.GOV, Attn:* Desk Officer for the Administration for Children and Families.

Dated: July 21, 2010.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–18170 Filed 7–23–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Request for State Data Needed to Determine Amount of a Tribal Family Assistance Grant.

OMB No.: 0970–0173.

Description: 42 U.S.C. 612 (Section 412 of the Social Security Act) gives federally recognized Indian Tribes the opportunity to apply to operate a Tribal Temporary Assistance for Needy Families (TANF) program. The Act specifies that the Secretary shall use State-submitted data to determine the amount of the grant to the Tribe. This form (letter) is used to request those data from the States. ACF is proposing to extend this information collection without change.

Respondents: States that have Indian Tribes applying to operate a TANF program.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Request for State Data Needed to Determine the Amount of Tribal Family Assistance Grant	4	1	42	168

Estimated Total Annual Burden Hours: 168.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it

within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following:

Office of Management and Budget, Paperwork Reduction Project. Fax: 202–395–7285. E-mail: *OIRA_SUBMISSION@OMB.EOP.GOV.* Attn: Desk Officer for the Administration for Children and Families.

Dated: July 21, 2010.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–18171 Filed 7–23–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2336–PN]

Medicare and Medicaid Programs; Application by Det Norske Veritas Healthcare for Deeming Authority for Critical Access Hospitals (CAHs)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from Det Norske Veritas Healthcare (DNVHC) for recognition as a national accrediting organization for critical access hospitals (CAHs) that wish to participate in the Medicare or Medicaid programs.

Section 1865(a)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 25, 2010.

ADDRESSES: In commenting, please refer to file code CMS–2336–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2336–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2336–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a Critical Access Hospital (CAH), provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. Regulations concerning provider agreements are in 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are in 42 CFR part 488. The regulations at 42 CFR part 485, subpart F specify the conditions that a CAH must meet in order to participate in the Medicare program. The scope of covered services and the conditions for Medicare payment for CAHs are set forth at § 413.70.

Generally, in order to enter into a provider agreement with the Medicare program, a CAH must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 485 of our CMS regulations. Thereafter, the CAH is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.