particular, the topical module will provide end-point estimates for many of the Healthy People 2000 Objectives. The Basic Module of the new data system is expected to be in the field at least until 2006. The total annual burden hours are 57,000.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hrs.)
Family Core (adult family member)	42,000	1	0.5
Adult Core (sample adult)	42,000	1	0.5
Child Core (sample child)	18,000	1	0.25
Prevention Module (sample adult)	42,000	1	0.25

Dated: August 20, 1997.

Wilma G. Johnson,

Acting Associate Director for Policy Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 97–22614 Filed 8–25–97; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Draft Document: Reporting of Pregnancy Success Rates From Assisted Reproductive Technology Programs; Notice of Comment Period

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS).

ACTION: Notice; request for comment.

SUMMARY: This notice is a request for comment and review of the draft document for the Reporting of Pregnancy Success Rates from Assisted Reproductive Technology (ART) Programs as required by the Fertility Clinic Success Rate and Certification Act of 1992 (FCSRCA).

DATES: This notice is effective for the calendar year 1997 and beyond. In order to report outcomes of pregnancies during a calendar year, clinic specific data will be collected through October of the following calendar year (e.g., outcomes of pregnancies occurring during calendar year 1997 will be collected through October 1998). CDC will publish its first annual report under this notice in March 1999.

To ensure consideration, written comments on this document must be received on or before September 25, 1997.

ADDRESSES: Comments shall be submitted to: George Walter, M.S.P.H., Women's Health and Fertility Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), Mailstop K–34, 4770 Buford Hwy, NE., Atlanta, Georgia 30341–3724.

FOR FURTHER INFORMATION CONTACT: George Walter, M.S.P.H., telephone (770) 488–5204, E–Mail Address: GBW4@CDC.GOV.

SUPPLEMENTARY INFORMATION: Section 2(a) of Pub. L. 102–493 (42 U.S.C. 263a–1) requires that each ART program shall annually report to the Secretary through the Centers for Disease Control and Prevention—(1) pregnancy success rates achieved by such ART program, and (2) the identity of each embryo laboratory used by such ART program and whether the laboratory is certified or has applied for such certification under this act.

Pub. L. 102–493, Section 8 (42 U.S.C. 263a–7) defines ''assisted reproductive technology'' (ART) as ''all treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and such other specific technologies as the Secretary may include in this definition, after making public any proposed definition in such manner as to facilitate comment from any person (including any Federal or other public agency).''

The Secretary is directed in Section 2(b) to define pregnancy success rates and ''make public any proposed definition in such a manner as to facilitate comment from any person during its development.''

Section 2c states: In developing the definitions under subsection (b), ''the Secretary shall consult with appropriate consumer and professional organizations with expertise in using, providing, and evaluating professional services and embryo laboratories associated with assisted reproductive technologies.''

Section 6 requires the Secretary, through the CDC, to annually ''publish and distribute to the States and the public—pregnancy success rates reported to the Secretary under section 2(a)(1) and, in the case of an assisted reproductive technology program which failed to report one or more success rates as required under each section, the name of each such program and each pregnancy success rate which the program failed to report.''

CDC has prepared these proposed reporting requirements after discussion with representatives of the Society for ART (a national professional association of ART clinical programs), the American Society for Reproductive Medicine (a national society of professional individuals who work with infertility issues), the College of American Pathologists (a national professional association of pathologists having an accreditation program for reproductive laboratories), the American College of Obstetricians and Gynecologists (a national society of obstetricians and gynecologists), RESOLVE (a national consumer association of couples with infertility diagnoses), and the New England Patients' Rights Group (a regional consumer association concerned with patients' rights and informed consent issues), as well as a variety of individuals with expertise and interest in this field.

This notice provides opportunity for public review and comment (see appendix).

Dated: August 20, 1997.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

Appendix: Notice for the Reporting of Pregnancy Success Rates From Assisted Reproductive Technology Programs

Introduction

This notice includes four sections:

I. Who Reports * * * describes who shall report to CDC.

II. Description of Reporting Process * * * describes the reporting system and process for reporting by each ART clinic.

III. Proposed Data to be Reported * * * includes the definition of terms used in the reporting database. These definitions are provided only for the purpose of clarity in reporting data and are not intended to define standards of medical care.

IV. Definitions * * * describes terms, and how pregnancy success rates will be defined and reported, and outlines the topics and analyses that will be included in the annual published reports, using the data collected in the reporting database.

I. Who Reports

The Fertility Clinic Success Rate and Certification Act of 1992 (FCSRCA) requires that each assisted reproductive technology program shall annually report to the Secretary of the Department of Health and Human Services through the CDC pregnancy success rates and the certification status of its embryology laboratory.

The Society for Assisted Reproductive Technology (SART), an affiliate of the

American Society for Reproductive Medicine (ASRM), maintains a national database of cycle specific data reported by each of its members. As a condition of SART membership, each ART clinic must submit clinic specific data to SART and agree to on site date validation site visits by SART.

CDC has reviewed the SART reporting database and system and found that it provides the necessary information to publish an annual report as required by the FCSRCA. Rather than duplicate SART's reporting system, and thereby burden ART clinics and patients, CDC will contract with the SART to obtain a copy of their clinic specific database.

ART clinics that participate in the ASRM/SART reporting system as described in this notice, will be considered to be in compliance with the reporting requirements of FCSRCA.

Any ART program that is not a member of SART shall contact CDC for reporting information, instructions, and fees charged (fees are for the purposes of covering all costs associated with this activity, including data collection, processing, analysis, publication, and administration.)

Contact George Walter, M.S.P.H., telephone (770) 488–5204.

II. Description of Reporting Process

A. Reporting Activities

SART issues a unique clinic code, computer software for their database reporting system, and all necessary reporting instructions.

Each patient receiving ART in a clinic is registered in the system with a unique, clinic-assigned identifier and should be entered into the reporting database when her cycle is initiated. Each cycle of each patient also receives a unique cycle code for that patient. In the reporting system, the patient is identified by the center code, the patient code, and the cycle code assigned by the clinic; the patient's name is not included in the reporting database. However, the individual clinics must be able to use these codes to link every cycle to a specific patient (see below). The following patients are included in the reporting database: (1) all women undergoing ART, (2) all women undergoing ovarian stimulation or monitoring with the intention of undergoing ART (this includes women whose cycles are canceled for any reason); (3) all women providing donor oocytes, and (4) all women undergoing an embryo thawing with the intention of transferring cryopreserved embryos.

Clinic patitents will be informed through consent forms that their cycle specific data will be provided to the CDC and that all personal identifiers submitted to CDC in the SART data set will be protected under the Privacy Act. If a patient indicates that they do not want their personal identifier reported, the personal identifier will not be included.

The CDC will retain a copy of each of SART's annual data files. These will be used for epidemiologic analysis and for the purpose of publishing an annual report as required.

B. External Validation of Clinic Data

Every clinic will maintain a copy of all information included in the reporting database and must be able to link each patient, cycle and occyte retrieved from the reporting database to the appropriate medical and laboratory records for external validation activities.

On a periodic basis, ART clinical programs will be subject to external validation by SART of their reporting activities which will include review by appropriate professionals from outside the clinic staff. This review may include, but not be limited to, examination of medical and laboratory records, comparison of data in the reporting database with data in the medical record, and direct communication with patients included in the reporting database. Each patient included in the reporting database should be counseled that he or she may be contacted by professional reviewers as part of routine data validation and asked to confirm information provided in the database. Every patient should have an informed consent document in the medical record indicating that he or she has been counseled concerning this possible contact and has agreed or refused to participate in the data validation process.

C. Updating of Reporting Requirements

The field of ART is a rapidly developing medical science. These reporting requirements will be periodically reviewed and updated as new knowledge concerning ART methods and techniques becomes available. Such review will include consultation with professional and consumer groups and individuals, such as the consultations obtained for this initial notice. All notices for revision of the reporting requirements will be published in the **Federal Register** with a comment period.

III. Proposed Data To Be Reported*

A. Clinic Information

- Name and address.
- Unique clinic ID number.
- Name(s) of embryo laboratory(s) used by clinic.
- Years ART program has been practicing under the above clinic name.
- Number of ART patients seen during the reporting year.
- Total number of ART cycles performed during the reporting year.

B. Patient information

1. Identification

- Patient ID number (e.g., medical record number).
- Social Security Number.
- Date of birth.
- Race and ethnicity.

2. Reproductive History

- Gravidity.
- Prior total ART cycles (performed at reporting clinic, plus all other clinics).
- Prior live births.
- ART cycles since last birth (if applicable).

3. Cycle Specific Information

a. Identification

- Unique cycle specific number.
- Date ART initiated.
- Date ART canceled (if applicable).
- Date of Retrieval (if applicable).
- Date of transfer (if applicable).

b. Art Procedure Information

- Pre-treatment diagnosis (primary and secondary).
- Type of ART performed.
- Use of surrogacy/gestational carrier.
- Stimulation medication with dosage (if applicable).
- If canceled, reason for cancellation (illness, small number or no follicles), and if other forms of treatment such as artificial insemination (therapeutic insemination), timed intercourse, etc., are carried out.
- Number of oocytes retrieved (if applicable).
- Sperm source (e.g., partner, donor, or mixed) and motility.
- Use of micromanipulation for male factor (e.g., ICSI, PZD, or SUZI).
- Use of assisted hatching.
- Number of embryos frozen.
- Number of fresh (or thawed) embryos/oocytes transferred.

c. Outcome Information

- Results of pregnancy test and ultrasound (when applicable).
- Type of pregnancy (e.g., biochemical, clinical or ectopic).
- Date and number (in sacs) of pregnancy reduction.
- Outcome of clinical pregnancy (spontaneous or induced abortion, live birth, still birth).

* These items are currently collected by SART and will be purchased by CDC.

- Birth outcome (birth weight, birth defects, neonatal death).
- Descriptions of complications (hyper stimulation syndrome, anesthesia complications, hospitalization).

IV. Definitions

(Numbers in parentheses refer to references at end of this document.)

ART—Assisted reproductive technology, defined as all treatments or procedures which include the handling of human oocytes and sperm or embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, embryo cryopreservation, oocyte or embryo donation, and gestational surrogacy(2).

ART Cycle—ART cycles can be stimulated (use of ovulation induction) or unstimulated (natural cycle (1). An ART cycle is considered any cycle in which: (1) ART has been used, (2) in which the woman has undergone ovarian stimulation or monitoring with the intent of undergoing ART, or (3) in the case of cryopreserved embryos, in which embryos have been thawed with the intent of transfer.

ART Program or Clinic—A legal entity practicing under State law, recognizable to the consumer, that provides assisted reproductive technology to couples who have experienced infertility or are undergoing ART for other reasons. This can be an individual physician or a group of physicians who practice together and share resources and liability. If a program or clinic has undergone significant staffing changes such as changes in medical director, lab director, or ownership, but maintains the same or similar program name that is recognizable to the consumer, the practice is considered a continuation of an existing program. This definition precludes individual physicians who practice independently from pooling their results for purposes of data reporting.

ASRM—American Society for Reproductive Medicine.

Birth defect—Anomalies identified within the first two weeks of life that result in death or cause a serious disability requiring surgical and/or medical therapy (4). Specific anomalies to be identified include cardiac defect, cleft lip, cleft palate, genetic defect, and limb defect.

Biochemical pregnancy—A positive pregnancy test without the documented presence of a gestational sac.

Canceled cycle—An ART cycle in which ovarian stimulation or monitoring has been carried out with the intent of undergoing ART but which did not proceed to oocyte retrieval, or in the case of cryopreserved embryo cycles, to the transfer of embryos.

Center code—An identification number assigned to each ART clinical program by the reporting database operator.

Clinical pregnancy—An ultrasound-confirmed gestational sac within the uterus or the documented presence of intrauterine products of conception. Clinical pregnancies include all gestational sacs regardless of whether or not a heartbeat is observed or a fetal pole is established. This definition excludes ectopic pregnancy but includes pregnancies which end in spontaneous abortions, induced abortions, and deliveries (3).

Clomiphene citrate—An ovulation induction medication with the trade name of Clomid® or SeroPhene®.

Complication—A medical complication for the woman related to ART procedures, such as reactions to medications, anesthetic reaction, postsurgical bleeding, or infection.

Cryopreservation—A technique to preserve tissue, both ovarian and testicular, through freezing.

Cycle code—The ART cycle number for the particular patient. This code should be unique for each cycle in the same patient and is a separate number from the patient code. The patient code and cycle code together uniquely identify each cycle of each patient reported from the same clinic.

Cycle start date (cycle initiation date)—The cycle start date is the day that: (1) a patient in a stimulated cycle begins ovarian stimulation; (2) a patient in an unstimulated cycle begins cycle monitoring with the expectation of undergoing ART (including cryopreserved embryo transfer); or (3) a patient in a donor recipient or cryopreserved embryo cycle begins endometrial stimulation by exogenous sex steroids (includes gestational surrogacy). See also stimulated and unstimulated cycles.

Donor embryo—An embryo derived from the egg of a donor for transfer to a recipient. (4)

Donor recipient cycle—A cycle in which the patient receives a donor embryo.

Donor oocyte cycle—A cycle in which the patient donates some or all of her oocytes to a recipient.

Down regulation—Use of a GnRH agonist to effect ovarian suppression prior to the initiation of ovarian stimulation.

Ectopic pregnancy—A pregnancy in which the fertilized egg implants anywhere but in the uterine cavity (usually in the fallopian tube, the ovary, or the abdominal cavity) (3).

Embryo—The normally (2 pronuclei) fertilized egg that has undergone one or more divisions (8).

Embryo transfer—Introduction of embryos into a woman's uterus after in vitro fertilization (3).

Endometriosis—The presence of tissue resembling endometrium in abnormal locations (locations outside the uterus) such as the ovaries, fallopian tubes, and abdominal cavity (4).

Fertilization—The penetration of the egg by the sperm and fusion of genetic materials to result in the development of a fertilized egg (or zygote).

Flare protocol—Use of a GnRH agonist starting with or after onset of menses of the cycle being entered to augment stimulation.

Fress zygotes or embryos—Zygotes or embryos which have not been cryopreserved. Such zygotes or embryos may have been conceived using fresh or frozen sperm.

FSH—Follicle stimulating hormone. A hormone produced and released from the pituitary that stimulates the ovary to ripen a follicle for ovulation.

Gamete intrafallopian transfer (GIFT)—An ART procedure that involves removing eggs from the woman's ovary, combining them with sperm, and immediately injecting the eggs and sperm into the fallopian tube. Fertilization takes place inside the fallopian tube. (4)

GnRHa—Gonadotropin-releasing hormone agonist (Lupron®, Synarel® and ''new'' products (high purified or recombinant)).

Gestational carrier—A woman who gestates an embryo which did not develop from her egg with the expectation of returning the infant to its genetic parents.

Gestational sac—A fluid-filled structure that develops within the uterus early in pregnancy (1).

Hatching (Assisted)—A micromanipulation technique which involves making a small opening in the zona wall of the embryo to enhance implantation (8).

Human chorionic gonadotrophin (hCG)—A hormone secreted by the products of conception derived from the urine of pregnant women. HCG is used to ripen the egg and trigger ovulation (8).

Human menopausal gonadotrophin (hMG)—A hormone extracted from the urine of post-menopausal women. It is rich in the hormones FSH (follicle stimulating hormone) and LH (luteinizing hormone) and is used to stimulate follicular development and ovulation (8).

Intrauterine Insemination (IUI)—The transfer of washed semen into a woman's uterus.

Intracytoplasmic sperm injection (ICSI)—The placement of a single sperm into the ooplasm of an oocyte by micro-operative techniques.

In vitro fertilization (IVF)—A method of assisted reproduction that involves removing eggs from a women's ovaries, combining them with sperm in the laboratory and, if fertilized, replacing the resulting embryo into the women's uterus. (4)

Live birth—Any infant delivered with signs of life (delivered with assigned 1 or 5 minute Apgar scores of 1 or greater), at greater than or equal to 20 gestational weeks.

Male factor—A deficiency in quantity and/or quality of sperm preventing successful fertilization. SART defines male factor as a sperm count of less than 20 million/milliliter and/or a motility of 40 percent or less. Frozen semen from the male partner is classified by its original fresh characteristics, not its post-thaw values. If donor sperm are used alone or in combination with male partner's sperm, the cycle is not classified as male factor (3).

Multiple pregnancy—A pregnancy with more than one fetus.

Neonatal death—Death of a live-born infant before completion of the 28th day of life.

Oocyte—The female reproductive cell, also called an egg.

Oocyte donation—Removal of an egg from one women for eventual transfer into the fallopian tube (GIFT) or for a ZIFT or IVF embryo transfer to another woman. The donor relinquishes all parental rights to any resulting offspring, while the recipient women retains all parental rights of any resulting offspring.

Oocyte donor—A woman who undergoes a donor oocyte cycle (see donor cycle).

Oocyte retrieval—A procedure to collect the eggs contained within the ovarian follicles. This definition includes procedures in which oocyte recovery was attempted but not successful (3).

Oocyte transfer—In GIFT (see definition), transfer of retrieved eggs into a woman's fallopian tubes via laparoscopy. Includes attempted transfer, whether or not the transfer was successful (3).

Ovarian monitoring—Monitoring the development of ovarian follicles by ultrasound and/or blood or urine tests.

Ovarian stimulation—A series of drugs used to stimulate the ovary to develop follicles and eggs (8).

Ovulatory dysfunction—A factor causing reduced fecundity that is associated with structural, anatomic, or functional injury of one or both ovaries.

Ovulation induction—See stimulated cycle.

Ovulation drug—See stimulated cycle.

Pregnancy test—A blood test which determines the level of human chorionic gonadotropin; if it is elevated this documents a pregnancy which can be biochemical, ectopic or clinical.

Pregnancy reduction—A procedure in which the number of gestational sacs is reduced. It is used in women with multiple gestations, usually three or more, to decrease the number of fetuses a woman carries and improve the chances of survival of the remaining fetus(es) and the delivery of a healthy newborn(s).

SART—Society for Assisted Reproductive Technology.

Sperm—The male reproductive cell that has completed the process of meiosis and morphological differentiation.

Sperm concentration—The number of sperm identified on microscopic examination per milliliter of ejaculate.

Sperm donor—A man providing sperm for the fertilization procedures of a woman other than his sexual partner.

Spontaneous abortion (miscarriage)—A pregnancy ending in spontaneous loss of the embryo or fetus prior to completion of 20 weeks of gestation.

Stillbirth—Infant delivered without signs of life at 20 or greater weeks gestation.

Stimulated cycle—An ART cycle in which a women receives ovarian stimulation, including the use of clomiphene citrate, follicle stimulating hormone, or human menopausal gonadotrophin (4).

Thawed cycle—A cycle in which embryos previously frozen are thawed for embryo transfer.

Therapeutic or induced abortion—Ending a pregnancy by using an operative procedure to electively terminate the pregnancy.

Tubal factor—A factor causing reduced fecundity that is associated with structural, anatomic, or functional injury of one or both fallopian tubes.

Ultrasound—A technique for visualizing the follicles in the ovaries and the gestational sac or fetus in the uterus, allowing the estimation of size.

Unexplained cause of infertility—Infertility in which a couple has received a comprehensive evaluation without identification of an etiology for the failure to conceive (7).

Unstimulated cycle—An ART cycle in which the woman does not receive ovulation stimulation, except for the possible use of human chorionic gonadotropin. Instead, only natural follicular development occurs (3).

Uterine factor—A factor causing reduced fecundity that is associated with structural, anatomic, or functional injury to the uterus.

Zygote—A normal (2 pronuclei) fertilized egg before cell division begins (1).

Zygote intra fallopian transfer (ZIFT)—Eggs are collected and fertilized, and the resulting zygote is then transferred to the fallopian tube (4).

III. Content of Published Reports

These data can be used to provide a useful picture of the national rates of pregnancy in ART as well as clinic-specific rates (6). The annual report is expected to have two components:

(1) A national component which will provide a comprehensive picture of success rates given a variety of factors including age, diagnosis, type of ART procedure, number of embryos transferred, etc. This is possible because the large number of cycles at the national level allows accurate statistical reporting of success rates, which is not possible with the smaller number of cycles carried out in individual clinics.

(2) A clinic-specific component which will provide success rates for all assisted reproductive technologies using fresh embryos (IVF, GIFT, ZIFT, and combinations of these), success rates for cryopreserved embryos, success rates for donor embryos and the percentage of multiple pregnancies (twins and triplets or greater). An age-adjusted rate will be published with the 95 percent confidence interval. When numbers permit, success rates will also be reported by specific age groups. In addition, the clinic-specific component will provide other information which may be useful to the consumer, such as the number of cycles carried out, the percent distribution of types of ART, the types of infertility problems the clinic sees, and the average number of embryos transferred per cycle.

Both components will be available to the general public. Pregnancy success rates will be defined and characterized as described below. The following information will be emphasized in the published annual reports. As resources allow, additional information may also be published in supplemental reports.

1. The rate of live births after completion of ART according to the number of:

a. All ovarian stimulation or monitoring procedures (cycle).

b. Oocyte retrieval procedures.

c. Embryo (or zygote, or oocyte) transfer procedures.

2. Frequency of:

a. Multiple gestations.

b. Cancellations.

3. The number of cycles carried out.

4. The average number of embryos transferred per cycle.

5. The rates in (1), (2a), and (4) will be categorized for:

a. ART using fresh embryos, those using cryo-preserved embryos only, and those using donor oocytes.

b. Age of woman at time of cycle (<35, 35–39 and >39).

6. To aid in the interpretation of rates, the following information will be included:

a. Clinic profile—What types of services the clinic offers (e.g., surrogacy, single women); the percentage of ART procedures which are IVF, GIFT, ZIFT; the percentage of procedures involving ICSI; the percentage of multiple pregnancies per transfer and the percentage of these multiple pregnancies which underwent selective reduction; and the percent distribution of causes of infertility.

b. Consumer-oriented explanation of all medical and statistical terms used in the report.

References

1. American Fertility Society. IVF & GIFT. A Patient's Guide to Assisted Reproductive Technology. American Fertility Society. Birmingham, Alabama, 1989.
2. The Fertility Clinic Success Rate and Certification Act of 1992 (Public Law 102–493).
3. American Fertility Society/Society for Reproductive Technology. Instructions for SART Data Collection System, 1993. American Fertility Society/Society for Assisted Reproductive Technology, Birmingham, Alabama, 1994.
4. American Fertility Society. Infertility: An Overview. A Guide for Patients. American Fertility Society, Birmingham, Alabama, 1994.
5. American Fertility Society. Investigation of the Infertile Couple. American Fertility Society, Birmingham, Alabama, 1991.
6. Wilcox LS, Peterson HB, Haseltine FP, Martin MC. Defining and Interpreting Pregnancy Success Rates for In Vitro Fertilization. Fertility and Sterility 1993; 60: 18–25.
7. Jones HW. On Reporting Pregnancies by Assisted Reproductive Technology. Fertility and Sterility 1993; 60: 759–761.
8. RESOLVE Assisted Reproductive Technologies Workbook RESOLVE, Inc., Boston, MA, 1994.

[FR Doc. 97–22611 Filed 8–25–97; 8:45 am]

BILLING CODE 4163–18–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request Proposed Projects

Title: Temporary Assistance for Needy Families (TANF) Tribal Plan.

OMB No.: 0970–0157.

Description: This document consists of an outline of how the Indian tribe's TANF program will be administered and operated. It is used to determine whether the plan is approvable and that the Indian tribe is eligible to receive a TANF grant.

Respondents: Tribal Govt.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
TANF Tribal Plan	18	1	60	1,080

Estimated Total Annual Burden Hours: 1,080.

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Information Services, Division of Information Resource Management Services, 370 L'Enfant Promenade, S.W., Washington, D.C. 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: August 20, 1997.

Bob Sargis,

Acting Reports Clearance Officer.

[FR Doc. 97–22619 Filed 8–25–97; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–484, HCFA–R–200]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), 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 functions;