holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than February 3, 2005.

A. Federal Reserve Bank of Atlanta (Sue Costello, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30303:

1. Community Bancshares of Mississippi, Inc. Employee Stock Ownership Plan, Brandon, Mississippi; to become a bank holding company by acquiring 58.6 percent of the voting shares of Community Bancshares of Mississippi, Inc., Brandon, Mississippi, and thereby indirectly acquire voting shares of Community Bank of Mississippi, Forest, Mississippi.

B. Federal Reserve Bank of Chicago (Patrick Wilder, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. Arthur R. Murray, Inc., Milford, Illinois; to acquire 100 percent of the voting shares of Dewey State Bank, Dewey, Illinois.

2. Country Bancorporation, Crawfordsville, Iowa; to acquire 100 percent of the voting shares of White State Bank, South English, Iowa.

3. Alpha Financial Group, Inc. Employee Stock Ownership Plan, Toluca, Illinois; to acquire up to 45.57 percent of the voting shares of Alpha Financial Group, Toluca, Illinois, and thereby indirectly acquire Alpha Community Bank, Toluca, Illinois.

C. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63166–2034:

1. Ozarks Legacy Community Financial, Inc., Thayer, Missouri; to become a bank holding company by acquiring at least 91.3 percent of the voting shares of Bank of Thayer, Thayer, Missouri.

Board of Governors of the Federal Reserve System, January 4, 2005.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 05–392 Filed 1–7–05; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[14Day–05–AR]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call the CDC Reports Clearance Officer at (404) 371–5978. CDC is requesting an emergency clearance for this data collection with a fourteen-day public comment period. CDC is requesting OMB approval of this package fourteen days after the end of the public comment period.

Comments are invited 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) ways to enhance 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. As this is an emergency clearance, please direct comments to the CDC Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395–6974. Comments should be received within fourteen days of this notice.

Proposed Project

Operations and Scope of Public Sexually Transmitted Disease (STD) Clinics in the U.S. States and Territories—New—National Center for HIV, STD, and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC).

Many clinics around the United States (U.S.) provide care specifically targeted toward people infected with or at risk for sexually transmitted diseases. These clinics are an important community resource in many areas because they provide specialized, affordable, expert care for clients. However, little is known about the number of public clinics in the U.S. that offer categorical STD services, their geographical location, or the range and quality of services offered. Understanding the characteristics and range of public STD clinics in the U.S. and the communities they serve will provide important information about access to STD care in the public setting, as well as identify needed resources. The location of clinics can be compared to local population size and STD morbidity to assess coverage. In addition, clinic information can be used to supplement the referral database for the CDC National STD and AIDS Hotline; to assist the STD clinics in networking with each other; and to provide professionals working with STDs a more accurate and well-rounded national picture of the clinics and the communities they serve. Additional information can also be gathered to assist in developing recommendations, guidelines, programs, and activities.

CDC proposes to mail a brief survey to approximately 2,800 public health clinics in the United States regarding the range of services offered at the clinics, source of their funding, and composition of clinic staff. Respondents will be provided a stamped addressed envelope to return the survey. The only cost to respondents is their time to complete the survey.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Public Health Clinics	2,800	1	15/60	700
Total				700

Dated: December 29, 2004.

Alvin Hall,

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

[FR Doc. 05–410 Filed 1–7–05; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Indiana State Plan Amendment 02–021

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on January 20, 2005, at 10 a.m., 233 North Michigan Avenue, Minnesota Room, Chicago, Illinois 60601 to reconsider the decision to disapprove Indiana State Plan Amendment (SPA) 02–021.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by January 25, 2005.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, LB–23–20, Lord Baltimore Drive, Baltimore, Maryland 21244, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider the decision to disapprove Indiana Medicaid State Plan Amendment (SPA) 02–021, which was submitted on December 27, 2002.

In SPA 02–021, Indiana proposed to expand the State's Medicaid mental health rehabilitation benefit to include services furnished by five types of child care facilities to inpatients in the facilities. The State incorporated into the SPA portions of the Indiana State code (470 IAC 3–11, 470 IAC 3–12, 470 IAC 3–13, 470 IAC 3–14, and 470 IAC 3–15) that govern the operation of these facilities.

At issue in this reconsideration is whether SPA 02–021 is consistent with the requirements contained in sections 1902(a)(10), 1902(a)(19), 1902(a)(30)(A), and 1902(a)(4) of the Social Security Act (the Act) as described in more detail below. In general, the Centers for Medicare & Medicaid Services (CMS) found that the SPA had four basic problems: (1) The proposed services would be provided to individuals under age 65 who are patients in institutions for mental diseases (IMDs) (that are not juvenile psychiatric hospitals) and who have not been determined eligible for Medicaid; (2) the proposed services would be provided on order of individuals who are neither physicians nor licensed practitioners; (3) the proposed services would be provided in facilities which permit use of mechanical restraints and provide for seclusion of children and which, therefore, cannot be considered to be ''in the best interests'' of the recipients; and (4) the proposed payment methodology includes items not encompassed in the definition of Medicaid rehabilitation services and improperly includes payment for state administrative costs.

More specifically, at issue is whether the proposed SPA complies with the requirements of section 1902(a)(10) of the Act, which provides generally that state plans must make ''medical assistance'' as defined in section 1905(a) of the Act, available to eligible individuals. The definition of medical assistance at section 1905(a)(27), excludes payment for care and services for individuals under age 65 who are patients in institutions for mental diseases (IMDs), except payment for juvenile psychiatric hospital services pursuant to section 1905(a)(16) of the Act. Indiana proposed to furnish services to individuals who are under age 65 in institutions that appear to meet the definition of an IMD at section 1905(i) of the Act and applicable Federal regulations at 42 CFR 435.1009. However, these facilities do not provide services that meet the definition of inpatient psychiatric hospital services contained in section 1905(h) of the Act and do not comply with the regulatory requirements for providers of inpatient psychiatric hospital services set forth at 42 CFR 483 Subpart G (concerning use of restraint or seclusion). Thus, the State has failed to establish that the services are within the scope of medical assistance that is authorized under the Act.

In addition, section 1905(a)(13) of the Act defines rehabilitative services as those that are recommended by a physician or other licensed practitioner of the healing arts. The proposed SPA would include services that are recommended by individuals who are neither physicians nor licensed practitioners, but who are operating under the supervision of these individuals. Nor do the proposed services meet the requirements or services in any inpatient setting within the scope of medical assistance (hospitals, nursing facilities, psychiatric hospital services for juveniles, or intermediate care facilities for the mentally retarded).

Finally, section 1905(a) of the Act defines the term ''medical assistance'' as payment of part or all of the cost of care and services furnished to eligible individuals. The reimbursement section of this amendment, detailed at section 4.2.2 of the Indiana Residential Care Reimbursement Rate Establishment document, and included in Attachment 4.19B of this amendment, would provide payment for services furnished to individuals who have not been determined eligible for Medicaid.

In addition, at issue is whether the proposed SPA is consistent with the requirement in section 1902(a)(19) of the Act that services be provided ''in the best interests of the recipients.'' Indiana permits the use of mechanical restraints and provides for extended periods of seclusion of children in the facilities covered by this amendment. CMS has determined that these policies, defined in the Indiana Administrative Code (470 IAC 3–11, 470 IAC 3–12, and 470 IAC 3–13) and incorporated in this amendment by reference, would endanger the health and welfare of the victims of these procedures, and cannot be considered to be in the best interests of the children affected.

Finally, at issue is whether the proposed payment methodology complies with section 1902(a)(30)(A) of the Act, which requires that payments for services under the plan be ''consistent with efficiency, economy, and quality of care,'' and with section 1902(a)(4) which requires that the State use methods of administration that are found by the Secretary to be ''necessary for the proper and efficient operation of the plan.'' The payment methodology proposed by the State includes payment for numerous cost items, including elements of room and board and transportation services, that are not encompassed in the definition of Medicaid rehabilitation services. For this reason, CMS found that the State has not documented that the proposed payment methodology would be efficient or economical, as required by section 1902(a)(30)(A) of the Act. Furthermore, CMS determined that the payment methodology improperly includes payment for State administrative costs as medical assistance. The amendment would include Medicaid administrative costs as part of the payment to providers and thus would likely result in incorrect payment of FFP. Because the proposed payment methodology commingles medical assistance and administrative costs, it is not consistent with the requirement for proper and efficient