SEC: Mary Ann Gadziala, Associate Director, Office of Compliance Inspections and Examinations, or Catherine McGuire, Chief Counsel, Linda Stamp Sundberg, Attorney Fellow, or Randall W. Roy, Special Counsel, at (202) 942–0073, Division of Market Regulation, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–1001.

SUPPLEMENTARY INFORMATION: On May 19, 2004, the Agencies requested comment on their Interagency Statement concerning the complex structured finance activities of financial institutions supervised by the Agencies (national and state banks; bank holding companies; federal and state savings associations; savings and loan holding companies; and SEC-registered broker-dealers and investment advisors). The Interagency Statement describes the types of internal controls and risk management procedures that the Agencies believe are particularly effective in assisting financial institutions to identify and address the reputational, legal, and other risks associated with complex structured finance transactions. The Interagency Statement, among other things, provides that financial institutions should have effective policies and procedures in place to identify those complex structured finance transactions that may involve heightened reputational and legal risk, to ensure that these transactions receive enhanced scrutiny by the institution, and to ensure that the institution does not participate in illegal or inappropriate transactions.

Several trade associations that represent financial institutions have requested that the Agencies extend the public comment period for the Interagency Statement for an additional 30-day period. The trade associations have indicated that such an extension would enable them and their members to better analyze and address the substantive, operational and legal issues associated with the Interagency Statement

In light of these requests, the Agencies are providing the public additional time to comment on the proposed Interagency Statement.

You should submit your comments on the Interagency Statement by July 19, 2004.

Dated: June 16, 2004.

John D. Hawke, Jr.,

Comptroller of the Currency.

Dated: June 16, 2004.

James E. Gilleran,

Director, Office of Thrift Supervision.

By order of the Board of Governors of the Federal Reserve System.

Dated: June 16, 2004.

Jennifer J. Johnson,

Secretary of the Board.

Dated at Washington, DC, this 16th day of June, 2004.

Pursuant to the Order of the Board of Directors, Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

By the Securities and Exchange Commission.

Dated: June 16, 2004.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 04–14052 Filed 6–18–04; 8:45 am]

BILLING CODE 4810–33–P; 6720–01–P; 6210–01–P; 6714–01–P; 8010–01–P

FEDERAL HOUSING FINANCE BOARD

Sunshine Act Meeting Notice; Announcing a Partially Open Meeting of the Board of Directors

TIME AND DATE: The open portion of the meeting of the Board of Directors is scheduled to begin at 10 a.m. on Wednesday, June 23, 2004. The closed portion of the meeting will follow immediately the open portion of the meeting.

PLACE: Board Room, Second Floor, Federal Housing Finance Board, 1777 F Street, NW., Washington, DC 20006.

STATUS: The first portion of the meeting will be open to the public. The final portion of the meeting will be closed to the public.

MATTER TO BE CONSIDERED AT THE OPEN PORTION OF MEETING: *Final Rule Regarding Registration of Federal Home Loan Bank Securities.* Consideration of a final rule to require each Federal Home Loan Bank to register a class of its securities with the Securities and Exchange Commission under the provisions of section 12(g) of the Securities Exchange Act of 1934.

MATTER TO BE CONSIDERED AT THE CLOSED PORTION OF MEETING: *Periodic Update of Examination Program Development and Supervisory Findings.*

CONTACT PERSON FOR MORE INFORMATION: Mary H. Gottlieb, Paralegal Specialist, Office of General Counsel, by telephone at 202/408–2826 or by electronic mail at *gottliebm@fhfb.gov.*

Dated: June 16, 2004.

By the Federal Housing Finance Board.

Mark J. Tenhundfeld,

General Counsel.

[FR Doc. 04–14030 Filed 6–16–04; 5:10 pm]

BILLING CODE 6725–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Combined Notice of Funding Availability for Programs To Improve Minority Health and Racial and Ethnic Disparities in Health

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science, Office of Minority Health.

Funding Opportunity Titles: This notice of funding availability includes three programs for FY 2004: (1) Community Programs to Improve Minority Health; (2) Bilingual/Bicultural Service Demonstration Grant Program; and (3) HIV/AIDS Health Promotion and Education Program

Announcement Type: Initial Announcement of Availability of Funds

Catalog of Federal Domestic Assistance Numbers: (1) Community Programs to Improve Minority Health—93.137; (2) Bilingual/Bicultural Service Demonstration Program—93.105; and (3) HIV/AIDS Health Promotion and Education Program—93.004.

DATES: Application Availability Date: June 21, 2004; Letter of Intent: July 6, 2004; Application Deadline: August 5, 2004.

SUMMARY: This announcement is made by the Department of Health and Human Services (HHS or Department), Office of Minority Health (OMH) located within the Office of Public Health and Science (OPHS), and working in a ''One-Department'' approach collaboratively with participating HHS agencies and programs (entities). The mission of the OMH is to improve the health of racial and ethnic minority populations through development of health policies and programs that will address health disparities and gaps. OMH serves as the focal point within the HHS for leadership, policy exchange, coalition and partnership building, and related efforts to address the health needs of racial and ethnic minorities. As part of a continuing HHS effort to improve the health and well being of racial and ethnic minorities, the Department announces availability of FY 2004

funding for the following three programs: Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, and HIV/AIDS Health Promotion and Education Program.

This is the first year that a single notice of funding availability has been issued for these three programs. In previous years, separate notices of funding availability were issued for each OMH program. The purpose of this single announcement is to make it easier for organizations such as community-based organizations, minority-serving organizations, faith based organizations, and tribal governments and organizations, who meet the eligibility criteria for each program, to identify and apply for FY 2004 OMH funding. As eligibility criteria vary for each program under this announcement, a single notice of funding availability may assist potential applicants to better identify the programs for which they can compete and to target proposals to the program(s) most suitable to the issues faced by their target population(s). This announcement should also assist eligible applicants to understand the range of issues that may be supported by the three programs and encourage collaborations among organizations that provide services to racial and ethnic minorities. Sections I (Funding Opportunities), II (Award Information), and III (Eligibility Information) contain program specific information for each of the programs included in this notice of funding availability. Sections IV (Application and Submission Information), V (Application Review Information), VI (Award Administration Information), and VII (Agency Contacts) contains common information that applies to all three programs identified in this notice of funding availability. Additional background information on each program may be found in Section VIII, Other Information.

SUPPLEMENTARY INFORMATION:

I. Funding Opportunity Description

Authority: These programs are authorized under section 1707 of the Public Health Service Act, as amended.

Purpose:

1. The Community Programs To Improve Minority Health

A. *Purpose:* The Community Programs to Improve Minority Health program seeks to improve the health status of racial and ethnic minority populations through health promotion and disease risk reduction intervention programs. It is expected that this program will demonstrate the effectiveness of:

- Community-based programs in developing, implementing, and conducting projects which integrate community-based screening and outreach services;
- Linkages and/or referrals for access and treatment to racial and ethnic minorities in high-risk, low-income communities; and
- Addressing sociocultural, linguistic, and other barriers to health care on health care outcomes.

B. *Project Outcomes:* Applicants requesting support under the Community Programs to Improve Minority Health must address project outcomes that can decrease the targeted health disparity(ies) as demonstrated through any or all of the following:

- Reduction in high-risk behaviors;
- Adoption of health promoting behaviors;
- Connection to a continuum of care;
- Improved access to health care; and/or
- Increased utilization of preventive health care and treatment services.

C. *Project Requirements:* Each project funded under this demonstration must:

i. Address at least one, but no more than three, of the health areas identified in the next section (Health Areas to be Addressed).

ii. Identify problems, such as gaps in services; or issues, such as access to health care, affecting the targeted health area to be addressed by the proposed project.

iii. Identify existing resources in the targeted health area which will be linked to the proposed project.

iv. Implement an approach to address the problem(s).

v. For those applicants applying as a coalition, the coalition must be established prior to submission of the application. The coalition must consist of at least three discrete organizations (*i.e.,* community-based minority-serving organization, health care facility, and other community entity) and have the capacity to:

- Plan and coordinate services which reduce existing sociocultural and/or linguistic, and other barriers to health care; and
- Provide screening, outreach, health care, and enabling services to ensure that clients follow-up with treatment and treatment referrals.

A single signed agreement between the applicant organization and coalition member organizations must be submitted with the application. The agreement must clearly detail the roles and resources that each entity will bring to the project, and the financial responsibility of the applicant organization to the coalition member organizations. The document must also state the duration and terms of the agreement. The agreement must cover the entire project period and be signed by individuals with the authority to represent the organizations (*e.g.,* president, chief executive officer, executive director).

D. *Health Areas To Be Addressed:* Applicants for Community Programs to Improve Minority Health projects must address at least one, but no more than three, of the following eight health areas which are among the Department's priorities.

- Adult Immunizations.
- Asthma.
- Cancer.
- Diabetes.
- Heart Disease and Stroke.
- HIV.
- Infant Mortality.
- Obesity and Overweight.

2. The Bilingual/Bicultural Service Demonstration Program

A. *Purpose:* The Bilingual/Bicultural Service Demonstration Program seeks to improve and expand the capacity for linguistic and cultural competence of health care professionals and paraprofessionals working with limited English proficient (LEP) minority communities and improve the accessibility and utilization of health care services among LEP minority populations. It is expected that this program will demonstrate the effectiveness of programs that involve partnerships between community-based, minority-serving organizations and health care facilities in a collaborative effort to:

- Address cultural and linguistic barriers to effective health care service delivery; and
- Increase access to quality and comprehensive health care for LEP minority populations living in the United States.

B. *Project Outcomes:* Applicants requesting support for projects under the Bilingual/Bicultural Service Demonstration Program must address project outcomes that can increase access to quality health care among LEP minority populations as demonstrated through any or all of the following:

- Reduction in high-risk behaviors;
- Adoption of health promoting behaviors;
- Connection to a continuum of care;
- Increased numbers of interpreters and interpretation services provided;
- Increased patient knowledge on how best to access care and participate in treatment decisions;
- Increased health provider knowledge on health disparities, and

culturally and linguistically appropriate health care services; and/or

• Increased utilization of preventive health care and treatment services.

C. *Project Requirements:* Each project funded under the Bilingual/Bicultural Service Demonstration Program must:

i. Address at least one, but no more than three, of the health areas identified in the next section (Health Areas to be Addressed).

ii. Carry out activities to improve and expand the capacity of health care providers and other health care professionals to deliver culturally and linguistically appropriate health care services to the target population. Examples include training providers on culturally competent practices or training interpreters.

iii. Carry out activities to improve access to health care for the LEP minority population. Examples include developing or identifying culturally appropriate health education materials, or offering consumer education and training on available health services and ways to access services.

iv. Have an established, formal linkage between the community-based organization and a health care facility, prior to submission of an application. The linkage must involve two separate and distinct entities.

A single signed agreement between the applicant organization and the partner organization must be submitted with the application. The agreement must specify in detail the roles and resources that each entity will bring to the project, and the terms of the linkage. The linkage agreement must cover the entire project period. The document must be signed by individuals with the authority to represent the organization (*e.g.,* president, chief executive officer, executive director).

D. *Health Areas To Be Addressed:* Applicants for a Bilingual/Bicultural Service Demonstration Program project must address at least one, but no more than three, of the following 12 health areas:

• Cancer
• Child and Adult Immunization
• Diabetes
• Environmental Health
• Heart Disease and Stroke
• HIV/AIDS and Sexually Transmitted Diseases
• Maternal, Infant, and Child Health
• Mental Health
• Obesity and Overweight
• Oral Health
• Substance Abuse
• Tobacco Use

3. HIV/AIDS Health Promotion and Education Program

A. *Purpose:* The HIV/AIDS Health Promotion and Education Program seeks to improve the health status, relative to HIV/AIDS, of targeted minority populations by engaging national minority-serving organizations in educational and outreach efforts. It is expected that this program will demonstrate that the involvement of national minority-serving institutions in the development and implementation of national model HIV/AIDS programs can serve a vital role in effectively reaching and educating hardly reached minority populations affected by and/or infected with HIV/AIDS.

B. *Project Outcomes:* Applicants requesting support for projects under the HIV/AIDS Health Promotion and Education Program must address project outcomes that can decrease the targeted health disparity(ies) as demonstrated through any or all of the following:

• Reduction in high-risk behaviors;
• Adoption of health promoting behaviors;
• Increased knowledge of the target population about the impact of HIV/AIDS;
• Increased knowledge of methods, such as abstinence, by which the transmission of HIV/AIDS can be prevented;
• Increased counseling and testing services for hardly reached and high risk minority populations; connection of high risk individuals to a continuum of care; increased patient knowledge on how best to access care and participate in treatment decisions; and/or
• Improved access to health care for hardly reached and high risk minority populations.

C. *Project Requirements:* Each project funded under the HIV/AIDS Health Promotion and Education Program must:

i. Identify problems or issues (*e.g.,* gaps in services, access to health care) affecting the targeted minority population(s) to be addressed by the proposed project.

ii. Carry out activities to identify unmet needs of the targeted, at risk or hardly reached minority population(s).

iii. Implement an approach to address the problem(s) and needs.

D. *Federal Involvement:* The HIV/AIDS Health Promotion and Education Program is a cooperative agreement program. Cooperative agreements include significant Federal interaction with the recipient organization in the implementation of program activities. For this program, this interaction includes, but is not limited to:

• Oversight and clearance for the implementation, conduct, and assessment of project activities.
• Collaborative work with funding recipients to develop and implement evaluation strategies incorporating the required Uniform Data Set which is to be used to report program information.
• Review and approval of assessment and evaluation instruments and/or plans.
• Direction to funding recipients on the submission of project data to OMH.
• Coordination and communication between funding recipients and other national organizations.
• Serving in a liaison capacity between funding recipients and appropriate federal government agencies.
• Planning and conducting grantee meeting(s).

II. Award Information

1. The Community Programs To Improve Minority Health

Estimated Funds Available for Competition: $3,400,000.
Anticipated Number of Awards: 17 to 30.
Range of Awards: $100,000 to $200,000 per year.
Anticipated Start Date: September 1, 2004.
Budget Period Length: 12 months.
Period of Performance: 3 Years (September 1, 2004 to August 31, 2007).
Type of Award: Grant.
Type of Application Accepted: New.

2. The Bilingual/Bicultural Service Demonstration Program

Estimated Funds Available for Competition: $2,500,000.
Anticipated Number of Awards: 16 to 20.
Range of Awards: $75,000 to $150,000 per year.
Anticipated Start Date: September 1, 2004.
Budget Period Length: 12 months.
Period of Performance: 3 Years (September 1, 2004 to August 31, 2007).
Type of Award: Grant.
Type of Application Accepted: New.

3. HIV/AIDS Health Promotion and Education Program

Estimated Funds Available for Competition: $3,000,000.
Anticipated Number of Awards: 20 to 22.
Range of Awards: $100,000 to $150,000 per year.
Anticipated Start Date: September 1, 2004.
Budget Period Length: 12 months.
Period of Performance: 3 Years (September 1, 2004 to August 31, 2007).

Type of Award: Cooperative Agreement (see Section I for description of Federal Involvement).

Type of Application Accepted: New.

III. Eligibility Information

1. Eligible Applicants

A. The Community Programs To Improve Minority Health

To qualify for funding, an applicant must be a:

- Private nonprofit, community-based, minority-serving organization which addresses health or human services (*see* Definitions);
- Community coalition, consisting of at least three discrete organizations with a community-based, minority-serving organization (*see* Definitions) as the lead organization;
- Public (local or tribal government) community-based organization which addresses health or human services; or
- Historically Black College or University (HBCU), Hispanic Serving Institution (HSI), or Tribal College or University (TCU).

The OMH is continuing, through this FY 2004 notice of funding availability, to promote the utilization of community coalitions and grassroots organizations to develop and implement health education, health promotion, and disease risk reduction programs. To that end, those organizations previously funded, or eligible to be funded, under the OMH's Health Disparities to Improve Minority Health Grant Program are eligible to apply for funding under the FY 2004 Community Programs to Improve Minority Health program.

Faith-based organizations that meet the above criteria are also eligible to apply. Tribal organizations and local affiliates of national, State-wide or regional organizations that meet the definition of a community-based minority-serving organization are also eligible to apply.

National, State-wide, and regional organizations may not apply for these grants. As the focus of the program is at the local, grassroots level, OMH is looking for organizations that have ties to the local community. National, state-wide, and regional organizations operate on a broader scale and are not as likely to effectively access hardly reached minority populations in the specific, local neighborhoods and communities.

Funding Priority: A priority in funding will be given to applicants that have an established community coalition of at least three discrete organizations that include a community-based minority-serving organization; a health care facility such as a community health center, migrant health center, health department, or medical center to provide treatment services; and a community organization such as a social service agency, business entity, or civic association.

B. The Bilingual/Bicultural Service Demonstration Program

To qualify for funding, an applicant must be a:

- Private nonprofit, community-based, minority-serving organization which addresses health and human services for LEP minority populations (*see* Definitions);
- Public (local or tribal government) community-based organization which addresses health or human services; or
- Tribal entity which addresses health and human services.

In addition, all applicants must provide services to a targeted LEP minority community and have an established linkage which:

- Involves two separate and distinct entities, one of which must be a community-based organization and the other a health care facility.
- Is documented in writing as specified in the section on Project Requirements.

This linkage is the foundation of this demonstration program to address cultural and linguistic barriers to effective health care service delivery, and to increase access to quality and comprehensive health care for LEP minority populations living in the United States.

Faith-based organizations that meet the above criteria are also eligible to apply for funding. Local affiliates of national organizations which have an established link with a health care facility are also eligible to apply.

National, State-wide, and regional organizations, universities, and other schools of higher learning may not apply for the Bilingual/Bicultural Service Demonstration grants. As the focus of the program is at the local, grassroots level, OMH is looking for organizations that have ties to the local community. National, State-wide, and regional organizations operate on a broader scale are not as likely to effectively access hardly reached minority populations in the specific, local neighborhoods and communities. Universities and other schools of higher learning are similarly excluded.

The organization submitting the application will:

- Serve as the lead agency for the project, responsible for its implementation and management; and
- Serve as the fiscal agent for the Federal grant awarded.

C. HIV/AIDS Health Promotion and Education Program

To qualify for funding, an applicant must be a private, nonprofit national minority-serving organization (*see* Definitions) that addresses HIV/AIDS minority health and human services. Examples of national minority-serving organizations that may apply include, but are not limited to:

- Associations/organizations representing community health organizations serving minority populations;
- Associations/organizations that focus on minority health, education, leadership development, and/or community partnerships; and
- Minority-focused health professions associations/organizations.

Faith-based organizations that meet the above criteria are eligible to apply for these HIV/AIDS Health Promotion and Education cooperative agreements.

Eligible organizations must have the capacity and ability to conduct HIV/AIDS-focused programs and activities related to health promotion and education that can be implemented on a national level. Because the intent of this program is to address the HIV/AIDS epidemic at the national level, only organizations with a national reach are eligible to apply.

2. Cost Sharing or Matching

Matching funds are not required for the Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration, and HIV/AIDS Health Promotion and Education Programs.

3. Other

A Letter of Intent (LOI) is required prior to submission of applications. *See* section IV.2 for formatting and submission requirements for the LOI.

Organizations applying for funds under the Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration, and HIV/AIDS Health Promotion and Education programs must submit documentation of nonprofit status with their applications. If documentation is not provided, the application will be considered non-responsive and will not be entered into the review process. The organization will be notified that the application did not meet the submission requirements.

Any of following serves as acceptable proof of nonprofit status:

- A reference to the applicant organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

• A copy of a currently valid IRS tax exemption certificate.

• A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

• A certified copy of the organization's certificate of incorporation or similar document that clearly establishes nonprofit status.

• Any of the above proof for a State or national organization and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If funding is requested in an amount greater than the ceiling of the award range, the application will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

Applications that are not complete or that do not conform to or address the criteria of this announcement will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

An organization may submit no more than one proposal for each of the three programs announced in this notice of funding availability. Organizations submitting more than one proposal for the same grant program will be deemed ineligible. The proposals will be returned without comment.

Organizations are not eligible to receive funding from more than one OMH grant program to carry out the same project and/or activities.

IV. Application and Submission Information

1. Address To Request Application Package

Application kits may be obtained:

• At *http://www.omhrc.gov.*

• By writing to Ms. Karen Campbell, Director, OPHS Office of Grants Management, Tower Building, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852; or contact the Office of Grants Management at (301) 594–0758. Please specify the OMH program(s) for which you are requesting an application kit.

2. Content and Form of Application Submission

A. Letter of Intent

A Letter of Intent (LOI) is required from all potential applicants for the purpose of planning the competitive review process. The narrative should be no more than one page, double-spaced, printed on one side, with one-inch margins, and unreduced 12-point font. LOIs should include the following information: (1) Program announcement title and number; (2) program that the application is being submitted under (*e.g.*, Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, or HIV/AIDS Health Promotion and Education Program); (3) health areas to be addressed; and (4) name of the applicant agency or organization, the official contact person and that person's telephone number, fax number, and mailing and e-mail addresses. Do not include a description of your proposed project.

On or before July 6, 2004, submit the LOI to: Ms. Karen Campbell, Director, OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. The LOI must be received by the OPHS Office of Grants Management by 5 p.m. e.d.t. on July 6, 2004. If an applicant does not submit an LOI by the established due date and time, the application will not be eligible for the review process.

B. Application

Applicants must use Grant Application PHS 5161–1 (Revised July 2000 and approved by OMB under Control Number 0348–0043). Forms to be completed include the Face Page/Cover Page (SF424), Checklist, Budget Information Forms for Non-Construction Programs (SF424A), Assurances-Non-Construction Programs (SF424B), and Certifications (pages 17–19 in PHS 5161–1). In addition to the application forms, applicants must provide a project narrative.

The project narrative (including summary and appendices) should be no more than 45 pages (55 pages for currently funded grantees). Currently funded OMH grantees (*i.e.*, Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, and Health Disparities in Minority Health grantees, and cooperative agreement grantees with HIV/AIDS projects) *must* include a Progress Report (maximum of 10 pages) in the appendix.

The narrative must be printed on one side of 8½ by 11 inch white paper, with one-inch margins, and 12-point font. All pages must be numbered sequentially including any appendices. (Do not use decimals or letters, such as: 1.3 or 2A). Do not staple or bind the application package. Use rubber bands or binder clips.

The narrative description of the project must contain the following:

i. Table of Contents: Include a Table of Contents with page numbers for each of the following sections.

ii. Project Summary: A project summary should be included that briefly describes key aspects of the Statement of Need, Objectives, Program Plan, Evaluation Plan, and Management Plan. The summary should be no more than 3 pages in length, double spaced.

iii. Statement of Need: Identify which of the health areas (up to 3) are being addressed (see Part I, Health Areas to be Addressed). Describe and document (with data) demographic information on the targeted geographic area, and the significance or prevalence of health problem(s) or issue(s) affecting the target minority group(s). Describe the minority group(s) targeted by the project (*e.g.*, race/ethnicity, age, gender, educational level/income). Describe the applicant organization's background, and the background/experience of the proposed linkage organization and rationale for inclusion in the project.

iv. Objectives: Include objectives stated in measurable terms and time frames for achievement.

v. Program Plan: Include a plan that clearly describes how the project will be carried out. Describe specific activities and strategies planned to achieve each objective. For each activity, describe how, when, where, by whom, and for whom the activity will be conducted. Describe any products to be developed by the project. Provide a time line chart.

vi. Evaluation Plan: Include a plan that identifies the expected results for each major objective and activity, and discuss the potential for replication. The description should include data collection and analysis methods, demographic data to be collected on project participants, process measures describing indicators to be used to monitor and measure progress toward achieving projected results by objectives, outcome measures which will show that the project has accomplished planned activities, and impact measures demonstrating achievement of the goal to positively affect health disparities.

vii. Management Plan: Provide a description of proposed program staff, including resumes and job descriptions for key staff, qualifications and responsibilities of each staff member, and percent of time each is committing to the project. Provide a description of duties for proposed consultants. Discuss the applicant organization's experience in managing projects/activities, especially those targeting the population to be served. Include a chart of the

organization's structure, showing who reports to whom, and of the project's structure.

viii. Appendices: Include documentation and other supporting information in this section, including Memorandum of Understanding, Progress Report, and other relevant information. (Appendices count toward the narrative page limit.)

In addition to the project narrative, the application must contain a detailed budget justification (does not count toward the page limitation). The detailed budget justification must include narrative and computation of expenditures for each year in which grant support is requested. The budget request should include funds to attend an annual OMH grantee meeting by key project staff.

The complete application kit will provide instructions on the content of each of these sections.

Obtaining a Data Universal Numbering System number (DUNS): All applicants are required to obtain a DUNS number as preparation for doing business electronically with the Federal Government. The DUNS number must be obtained prior to applying for OMH funds.

The DUNS number is a nine-character identification code provided by the commercial company Dun & Bradstreet, and serves as a unique identifier of business entities. There is no charge for requesting a DUNS number, and you may register and obtain a DUNS number by either of the following methods:

Telephone: 1–866–705–5711.

Web site: *https://eupdate.dnb.com/requestoptions.html.* Be sure to click on the link that reads, ''DUNS Number Only'' at the left hand, bottom corner of the screen to access the free registration page. Please note that registration via the Web site may take up to 30 business days to complete.

3. Submission Dates and Times

Letter of Intent Deadline Date: July 6, 2004.

Application Deadline Date: August 5, 2004.

Explanation of Deadlines: To receive consideration, Letters of Intent must be received by the OPHS Office of Grants Management by 5 p.m. e.d.t. on July 6, 2004. If an applicant does not submit a Letter of Intent prior to submitting an application, the application will not be eligible for review.

Grant applications must be received by the OPHS Office of Grants Management by 5 p.m. e.d.t. on August 5, 2004. OPHS will not acknowledge receipt of applications. Applications received after the exact date and time specified for receipt will not be accepted. The application due date requirement specified in this announcement supercedes the instructions in the PHS 5161–1. Applications submitted by facsimile transmission (fax) or any other electronic format will not be accepted. Applications which do not meet the deadline will be returned to the applicant unread.

Applications will be screened upon receipt. Applications that are not complete or that do not conform to, or address, the criteria of the applicable program will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

4. Intergovernmental Review

The Community Programs to Improve Minority Health and the Bilingual/Bicultural Service Demonstration Programs are subject to the requirements of Executive Order 12372 which allows states the option of setting up a system for reviewing applications from within their states for assistance under certain Federal programs. The application kits available under this notice will contain a list of states which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review. The SPOC list is also available on the Internet at the following address: *http://www.whitehouse.gov/omb/grants/spoc.html.* Applicants (other than federally recognized Indian tribes) should contact their SPOCs as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the application deadline established by the OPHS Grants Management Officer. The OMH does not guarantee that it will accommodate or explain its responses to State process recommendations received after that date. (*See* ''Intergovernmental Review of Federal Programs,'' Executive Order 12372, and 45 CFR Part 100 for a description of the review process and requirements.)

The Community Programs to Improve Minority Health and the Bilingual/Bicultural Service Demonstration Grant Programs are subject to Public Health Systems Reporting Requirements. Under these requirements, community-based non-governmental applicants must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based organizations within their jurisdictions.

Community-based non-governmental applicants are required to submit, no later than the Federal due date for receipt of the application, the following information to the head of the appropriate State and local health agencies in the area(s) to be impacted: (a) A copy of the face page of the application (SF 424), and (b) a summary of the project (PHSIS), not to exceed one page, which provides: (1) A description of the population to be served, (2) a summary of the services to be provided, and (3) a description of the coordination planned with the appropriate State or local health agencies. Copies of the letters forwarding the PHSIS to these authorities must be contained in the application materials submitted to the OPHS.

5. Funding Restrictions

Budget Request: If funding is requested in an amount greater than the ceiling of the award range, the application will be considered non-responsive and will not be entered into the review process. The application will be returned with notification that it did not meet the submission requirements.

Grant funds may be used to cover costs of:

- Personnel.
- Consultants.
- Equipment.
- Supplies (including screening and outreach supplies).
- Grant related travel (domestic only), including attendance at an annual OMH grantee meeting.
- Other grant related costs.

Grant funds may not be used for:

- Building alterations or renovations.
- Construction.
- Fund raising activities.
- Job training.
- Medical care, treatment or therapy.
- Political education and lobbying.
- Research studies involving human subjects.
- Vocational rehabilitation.

Guidance for completing the budget can be found in the Program Guidelines, which are included with the complete application kits.

6. Other Submission Requirements

Applications may only be submitted in hard copy. Send an original, signed in blue ink, and two copies of the complete grant application to Ms. Karen Campbell, Grants Management Officer,

Office of Grants Management, Office of Public Health and Science, Tower Building, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Applications submitted by e-mail, facsimile transmission (fax) or any other electronic format will not be accepted.

V. Application Review Information

1. Criteria

The technical review of Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, and HIV/AIDS Health Promotion and Education Program applications will consider the following five generic factors.

A. Factor 1: Program Plan (35%)

- Appropriateness of proposed approach and specific activities for each objective.
- Logic and sequencing of the planned approaches in relation to the objectives and program evaluation.
- Soundness of the established partnerships (*e.g.*, coalition, linkages).
- Likelihood of successful implementation of the project.

B. Factor 2: Evaluation (20%)

- Appropriateness of the proposed data collection, analysis and reporting procedures.
- Clarity of the intent and plans to document the activities and their outcomes.
- Potential for the proposed project to impact the health status of, and barriers to health care experienced by the targeted minority populations.
- Potential for replication of the project for similar target populations and communities.

C. Factor 3: Statement of Need (15%)

- Demonstrated knowledge of the problem at the national and/or local level as applicable.
- Significance and prevalence of the identified health problem(s) or health issue(s) in the proposed community and target population.
- Extent to which the applicant demonstrates access to the target community(ies), and whether it is well positioned and accepted within the community(ies) to be served.
- If applicable, demonstrated support and established linkage(s) in order to conduct the proposed model.
- Extent and documented outcome of past efforts and activities with the target population (Currently funded OMH grantees [*i.e.*, Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, and Health Disparities in Minority Health grantees, and cooperative agreement grantees with HIV/AIDS projects] *must* attach a progress report describing project accomplishments and outcomes.)

D. Factor 4: Objectives (15%)

- Merit of the objectives.
- Relevance to the program purpose, project outcomes and stated problem.
- Attainability of the objectives in the stated time frames.

E. Factor 5: Management Plan (15%)

- Applicant organization's capability to manage and evaluate the project as determined by:

—Qualifications and appropriateness of proposed staff or requirements for ''to be hired'' staff and consultants
—Proposed staff level of effort
—Management experience of the applicant
—The applicant's organizational structure

- Appropriateness of defined roles including staff reporting channels and that of any proposed contractors.
- Clear lines of authority among the proposed staff within and between participating organizations.

2. Review and Selection Process

Accepted Community Programs To Improve Minority Health, Bilingual/Bicultural Service Demonstration, and HIV/AIDS Health Promotion and Education Program applications will be reviewed for technical merit in accordance with PHS policies. Applications will be evaluated by an Objective Review Committee (ORC). Committee members are chosen for their expertise in minority health, health disparities, and their understanding of the unique health problems and related issues confronted by the racial and ethnic minority populations in the United States. Funding decisions will be determined by the Deputy Assistant Secretary for Minority Health who will take under consideration:

- The recommendations and ratings of the ORC
- Geographic and racial/ethnic distribution
- Health areas to be addressed
- Funding Priority

3. Anticipated Award Date

September 1, 2004.

VI. Award Administration Information

1. Award Notices

Successful applicants will receive a notification letter from the Deputy Assistant Secretary for Minority Health and a Notice of Grant Award (NGA), signed by the OPHS Grants Management Officer. The NGA shall be the only binding, authorizing document between the recipient and the Office of Minority Health.

Notification will be mailed to the Program Director/Principal Investigator identified in the application.

Unsuccessful applicants will receive a notification letter with the results of the review of their application from the Deputy Assistant Secretary for Minority Health.

2. Administrative and National Policy Requirements

In accepting this award, the grantee stipulates that the award and any activities thereunder are subject to all provisions of 45 CFR parts 74 and 92, currently in effect or implemented during the period of the grant.

The Buy American Act of 1933, as amended (41 U.S.C. 10a–10d), requires that Government agencies give priority to domestic products when making purchasing decisions. Therefore, to the greatest extent practicable, all equipment and products purchased with grant funds should be American-made.

A Notice providing information and guidance regarding the ''Government-wide Implementation of the President's Welfare-to-Work Initiative for Federal Grant Programs'' was published in the **Federal Register** on May 16, 1997. This initiative was designated to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the Notice is available electronically on the OMB home page at *http://www.whitehouse.gov/omb*.

The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, grantees shall clearly state the percentage and dollar amount of the total costs of the program or project which will be financed with Federal money and the percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

3. Reporting Requirements

A successful applicant under this notice will submit: (1) Semi-annual progress reports; (2) an annual Financial Status Report; and (3) a final progress report and Financial Status Report in the format established by the OMH, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program

Performance'', 45 CFR Part 74–51–74.52, with the exception of State and local governments to which 45 CFR Part 92, Subpart C reporting requirements apply.

Uniform Data Set: The Uniform Data Set (UDS) system is designed to assist in evaluating the effectiveness and impact of grant and cooperative agreement projects. All OMH grantees are required to report program information, using the Web-based UDS. Training will be provided to all new grantees (including cooperative agreement grantees) on the use of the UDS system, during the annual grantee meeting.

Grantees will be informed of the progress report due dates and means of submission. Instructions and report format will be provided prior to the required due date. The Annual Financial Status Report is due no later than 90 days after the close of each budget period. The final progress report and Financial Status Report are due 90 days after the end of the project period. Instructions and due dates will be provided prior to required submission.

VII. Agency Contacts

For questions on budget and business aspects of the application, contact Ms. Karen Campbell, Director, OPHS Office of Grants Management, Tower Building, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852. Ms. Campbell can be reached by telephone at (301) 594–0758.

For questions related to the Community Programs to Improve Minority Health, Bilingual/Bicultural Service Demonstration Program, and/or HIV/AIDS Health Promotion and Education Program or assistance in preparing a grant proposal, contact Ms. Cynthia Amis, Director, Division of Program Operations, Office of Minority Health, Tower Building, Suite 600, 1101 Wootton Parkway, Rockville, MD 20852. Ms. Amis can be reached by telephone at (301) 594–0769.

For additional technical assistance, contact the OMH Regional Minority Health Consultant for your region listed in your grant application kit.

For health information, call the OMH Resource Center (OMHRC) at 1–800–444–6472.

VIII. Other Information

1. Background

A. The Community Programs To Improve Minority Health

The mission of the OMH is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help to address disparities in health. Racial and ethnic minorities, as well as low income families and individuals in geographically isolated communities, suffer disproportionately from preventable chronic conditions and may experience poorer health outcomes than other Americans due to differences in access to health care and disparities in health care delivery. For example:

- In the U.S., rates of asthma deaths and hospitalizations have been decreasing; however, African Americans continue to have higher rates compared to whites. In 1999, the average age-adjusted asthma death rate for blacks was almost 39%, nearly 3 times that of whites (14%). Asthma also continues to be one of the leading causes of school absenteeism, limitations of activity, and disruption of family life in the U.S.[1]
- Cancer incidence and death rates vary by race, with blacks having a 10% higher cancer incidence rate and a 30% higher cancer death rate compared to whites, and lower cancer survival rates regardless of site or stage. Compared to whites, Hispanics have higher rates of cervical cancer; and Asians have higher rates of stomach and liver cancer.[2]
- American Indians, blacks and Hispanics have higher diabetes death rates, while blacks have a higher rate of serious complications from diabetes.[3]
- Mortality due to coronary heart disease is higher among blacks as compared with whites. Although high blood pressure, high cholesterol and smoking are the three most important risk factors for heart disease, Asian, Hispanic, and less educated adults are less likely to have their blood pressure monitored and their cholesterol checked.[4]
- Hispanics have higher incidence rates of AIDS compared to whites. While blacks make up 12% of the U.S. population, they account for 50% of the new HIV cases reported in year 2002; and deaths from HIV/AIDS are highest among black women age 25 to 44 and black men age 45 to 64.[5] [6]
- American Indian, black and Hawaiian mothers are more likely to have low birth weight infants compared to white mothers. With respect to mortality, black, Other Pacific Islander, American Indian and Alaska Native infants and infants of less educated mothers are more likely to die at birth than white infants.[7]
- In 1999, approximately 50% of black adults age 65 and over, and 55% of Hispanic adults in the same age category received influenza vaccines compared with 68% of whites.[8]
- The problem of obesity is greatest among black women (50%) and Mexican American women (40%) compared to white women (30%). Also, black and Mexican American adolescents ages 12 to 19 are more likely to be overweight (24%) than white adolescents (13%).[9]

In an effort to make a difference for those populations experiencing health disparities, The Department launched the *Closing the Health Gap Initiative*, targeting the following six health issue areas: infant mortality, cancer screening and management, cardiovascular disease and stroke, diabetes, HIV/AIDS, and child and adult immunizations. The Secretary of HHS, through the Healthy Lifestyles and Disease Prevention Initiative, is focusing efforts on obesity and overweight. In addition, asthma continues to be a Departmental priority. In support of these initiatives/priorities, the OMH is focusing its FY 2004 programs on the eight health issues identified above.

B. The Bilingual/Bicultural Service Demonstration Program

OMH is charged with carrying out programs to improve access to health care services for individuals with limited English proficiency, many of whom are members of racial or ethnic populations. OMH is committed to working with community-based organizations to improve and enhance access to quality and comprehensive health services for these populations. Limited English proficiency (LEP) and other barriers which inhibit interaction with health care providers or social service agencies, often result in delays or denial of care, and/or provision of inaccurate or incomplete health information to LEP minority individuals. To that end, OMH supports the Bilingual/ Bicultural Service Demonstration Program to build communication bridges and reduce the

[1] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report Surveillance for Asthma—United States, 1980–1999. 51(SS01); 1–13. March 29, 2002.

[2] National Cancer Institute. ''SEER Cancer Statistics Review 1975–2001.''

[3] National Center for Health Statistics. Health, United States, 2003. Hyattsville, Maryland: 2003.

[4] Centers for Disease Control and Prevention. Data 2010: Healthy People 2010 Database. 2004.

[5] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report—U.S. HIV and AIDS cases reported through December 2002, Vol. 14.

[6] National Center for Health Statistics. Health, United States, 2003. Hyattsville, Maryland: 2003.

[7] *Ibid.*

[8] Centers for Disease Control and Prevention. National Health Interview Survey—1999.

[9] *National Health and Nutrition Examination Survey*, ''Prevalence of Overweight and Obesity Among Adults: United States, 1999—2000,'' U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics, 2002.

linguistic, cultural and social barriers the LEP minority populations encounter when accessing health services.

According to the 2000 Census, more than 300 different languages are spoken in the United States, and 18% of the nation speak a language other than English at home. This percentage is an increase from the 1990 Census which reported that 14% of persons spoke a language other than English at home. In addition, the 2000 Census reported that 4.4 million households encompassing 11.9 million people are linguistically isolated, meaning that no person in the household speaks English ''very well.'' This is a significant increase from 1990 which reported that 2.9 million households encompassing 7.7 million people were linguistically isolated.

To improve services for LEP minority populations, it is essential that health care providers, health care professionals, and other staff become better informed about the diverse linguistic, cultural and medical backgrounds of the clientele. Enhancement of cultural and linguistic competency among providers not only improves the ability of providers to care for diverse populations, but also allows patients to better navigate the health care system.

To insure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, the OMH published the *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care* (U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report*, Washington, DC, March 2001). While these 14 standards are primarily directed at health care organizations, the principles and activities of culturally and linguistically appropriate services should be undertaken in partnership with communities being served. OMH encourages community-based minority-serving organizations to partner with health care facilities to implement activities addressing those CLAS standards that have applicability to the purposes of the Bilingual/Bicultural Service Demonstration Program. Potential applicants for the Bilingual/Bicultural Service Demonstration Program are encouraged to incorporate such activities into project plans. Additional information on CLAS standards may be found on the OMH Web site: *http://www.omhrc.gov/cultural.*

C. HIV/AIDS Health Promotion and Education Program

The *Census 2000 Brief*[10] reports the U.S. population as 281.4 million, with 36.4 million[11] Blacks or African Americans, or 12.9 percent; 35.3 million Hispanics, or 12.5 percent; approximately 12.8 million Asians/Native Hawaiians and Other Pacific Islanders, or 4.5 percent; and approximately 4 million American Indians/Alaska Natives or 1.5 percent of the total population. HIV/AIDS remains a disproportionate threat to minorities. As of December 31, 2002, the Centers for Disease Control and Prevention (CDC) received reports of 886,575 (cumulative) cases of persons with AIDS in the U.S.,[12] of whom 39 percent were Black or African American, and 18 percent were Hispanic.

Of the 43,950 AIDS cases reported to CDC during 2002, 43,792 were adult/adolescent and 158 were children (<13 years of age). For the adult/adolescent population, an estimated 76% were Black or African American, and 26% were Hispanic. Of the children reported with AIDS, an estimated 59 percent were Black non-Hispanic, and 19 percent were Hispanic.[13]

Through December 2002, the most common exposure category reported for AIDS cases among minority males was men who have sex with men; among the cumulative AIDS cases for males, 37% of Blacks, 42% of Hispanics, 70% of Asians and Pacific Islanders, and 55% of American Indian/Alaska Natives were in this exposure category.[14]

HIV infection among U.S. women has increased significantly over the last decade, especially in communities of color. Between 1985 and 1999, the proportion of all AIDS cases reported among adult and adolescent women more than tripled, from 7 to 23 percent. African American and Hispanic women account for more than three-fourths, or 82 percent, of the new HIV/AIDS cases reported among women in the U.S. Through December 2002, the most common exposure categories for AIDS cases among African American and Hispanic females were heterosexual contact (48%, Hispanic; 40%, African American) and injection drug use (38%, African American; 38%, Hispanic).[15]

The number of estimated deaths among persons with AIDS in 2002 represented a 14% decline since 1998; however, African Americans and Hispanics represented 52% and 19% of those deaths, respectively, compared to 28% for whites.[16]

The OMH is initiating the HIV/AIDS Health Promotion and Education program to support health promotion and education activities to reduce high risk behaviors, promote healthy behaviors, increase counseling and testing services, and improve access to health care for hardly reached or at-risk minority populations.

2. Healthy People 2010

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a PHS-led national activity announced in January 2000 to eliminate health disparities and improve years and quality of life. More information may be found on the Healthy People 2010 Web site: *http://www.healthypeople.gov* and copies of the document may be downloaded. Copies of the Healthy People 2010: Volumes I and II can be purchased by calling (202) 512–1800 (cost $70.00 for printed version; $20.00 for CD–ROM). Another reference is the *Healthy People 2000 Final Review—2001.* For 1 free copy of the *Healthy People 2010*, contact: The National Center for Health Statistics, Division of Data Services, 3311 Toledo Road, Hyattsville, MD 20782, or by telephone at (301) 458–4636. Ask for HHS Publication No. (PHS) 99–1256. This document may also be downloaded from: *http://www.heatlhypeople.gov.*

3. Definitions

For purposes of this grant program, the following definitions apply:

Community-Based Organizations—Private, nonprofit organizations *and* public organizations (local or tribal governments) that are representative of communities or significant segments of communities where the control and decisionmaking powers are located at the community level.

Community-Based, Minority-Serving Organization—A community-based organization that has a history of service to racial/ethnic minority populations. (*See* definition of *Minority Populations* below.)

Community Coalition—At least 3 discrete organizations and institutions

[10] U.S. Census Bureau, The Black Population: 2000—Census 2000 Brief, August 2001.

[11] This number includes individuals who self-reported as Black, or as Black and one or more other race on the Census 2000 questionnaire.

[12] HIV/AIDS Surveillance Report—U.S. HIV and AIDS cases reported through December 2002, Vol. 14.

[13] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report—U.S. HIV and AIDS Cases Reported Through December 2002, Vol. 14.

[14] *Ibid.*

[15] *Ibid.*

[16] *Ibid.*

in a given community. The organizations work together on specific community concerns, and seek resolution of those concerns. A formalized relationship documented by written memoranda of understanding/agreement signed by individuals with the authority to represent the organizations (*e.g.*, chief executive officer, executive director, president/chancellor) is required.

Cooperative Agreement—A financial assistance mechanism used in lieu of a grant when substantial Federal programmatic involvement with the recipient during performance is anticipated by the awarding office.

Cultural Competency—Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

Funding Priority—A factor(s) that causes a grant application to receive a fixed amount of extra rating points which may place that application ahead of others without the priority on a list of applicants recommended for funding by a review committee.

Health Care Facility—A private nonprofit or public facility that has an established record for providing comprehensive health care services to a targeted, racial/ethnic minority community.

A health care facility may be a hospital, outpatient medical facility, community health center, migrant health center, or a mental health center. Facilities providing only screening and referral activities are not included in this definition.

Limited-English-Proficient (LEP) Minority—People from *Minority Populations* (*see* definition below) with a primary language *other than* English. These individuals must communicate in their main language in order to participate effectively in and benefit from any aid, service or benefit provided by the health provider.

Minority Populations—American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander. (Revision to the Standards for the Classification of Federal Data on Race and Ethnicity, **Federal Register**, Vol. 62, No. 210, pg. 58782, October 30, 1997.)

National Minority-Serving Organization—A national non-profit organization whose mission focuses on issues affecting minority communities nationwide and that has a history of service to racial/ethnic minority populations.

Nonprofit Organizations—Corporations or associations, no part of whose net earnings may lawfully inure to the benefit of any private shareholder or individual. Proof of nonprofit status must be submitted by private nonprofit organizations with the application or, if previously filed with PHS, the applicant must state where and when the proof was submitting. (*See* Section III.3. Other, for acceptable evidence of nonprofit status.)

Sociocultural Barriers—Policies, practices, behaviors and beliefs that create obstacles to health care access and service delivery. Examples of sociocultural barriers include:

- Cultural differences between individuals and institutions;
- Cultural differences of beliefs about health and illness;
- Customs and lifestyles;
- Cultural differences in languages or nonverbal communication styles.

Dated: June 8, 2004.

Nathan Stinson,

Deputy Assistant Secretary for Minority Health.

[FR Doc. 04–13893 Filed 6–18–04; 8:45 am]

BILLING CODE 4150–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Request for Applications for the National Community Centers of Excellence in Women's Health (CCOE) Program

Announcement Type: Competitive Cooperative Agreement—FY 2004 Initial announcement.

Funding Opportunity Number: Not applicable.

Catalog of Federal Domestic Assistance: The Catalog of Federal Domestic Assistance number is 93.290.

Dates: To receive consideration applications must be received by the Office of Public Health and Science (OPHS) Grants Management Office no later than July 20, 2004, 5 p.m. eastern standard time.

Summary: The National Community Centers of Excellence in Women's Health (CCOE) program provides funding to community-based organizations to enhance their women's health program through the integration of the following six components: (1) Leadership development for women as health care consumers and providers, (2) training for lay, allied health, and professional health care providers that includes a rural health focus, (3) public education and outreach with special emphasis on outreach to Native American women and/or rural/frontier communities, (4) comprehensive health service delivery that includes gender and age-appropriate preventive services and allied health professionals as members of the comprehensive care team, (5) community-based research that uses the findings to improve the management and delivery of comprehensive, integrated care to all women, and (6) replication of the model in another community to improve health outcomes for underserved women. The CCOE program is not for the development of new programs or to fund direct service, but rather to *integrate*, coordinate, and strengthen linkages between activities/programs that are already underway in the community to reduce fragmentation in women's health services.

Under this announcement the Office on Women's Health (OWH) anticipates making, through the cooperative agreement grant mechanism, 2 to 4 new 5-year awards by September 30, 2004. Approximately $450,000 is available to make awards of up to $150,000 total cost (direct and indirect) for a 12-month budget period and $750,000 for the 5-year project period. Cost sharing and matching funds is not a requirement of this grant. The actual number of awards made will depend upon the quality of the applications received and the amount of funds available for the CCOE program. The government is not obligated to make any awards as a result of this announcement.

Eligible applicants are public or private nonprofit community-based hospitals, community health centers, and other community-based organizations serving underserved women. Community health centers funded under section 330 of the Public Health Service Act and faith-based organizations are also encouraged to apply. To increase the likelihood of funding a CCOE in Region VIII, in rural/frontier communities and in communities of Native American women, the OWH will award bonus points to applicants meeting these criteria. Application kits may be obtained from Ms. Karen Campbell, Director, OPHS Office of Grants Management, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852, telephone: (301) 594–0758, e-mail: *kcampbell@osophs.dhhs.gov.*

I. Funding Opportunity Description

Authority: This program is authorized by 42 U.S.C. 300u–2(a)(1), 300u–6(e). The primary purpose of the National Community Center of Excellence in Women's Health (CCOE) program is the