SUBCHAPTER M—INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 136—INDIAN HEALTH

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AUTHORITY: 25 U.S.C. 13; sec. 3, 68 Stat. 674 (42 U.S.C., 2001, 2003); Sec. 1, 42 Stat. 208 (25 U.S.C. 13); 42 U.S.C. 2001, unless otherwise noted.

Subpart A—Purpose and Definitions

SOURCE: 64 FR 58319, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002

§ 136.1 Definitions.

When used in this part:

Bureau of Indian Affairs (BIA) means the Bureau of Indian Affairs, Department of the Interior.

Indian includes Indians in the Continental United States, and Indians, Aleuts and Eskimos in Alaska.

Indian health program means the health services program for Indians administered by the Indian Health Service within the Department of Health and Human Services.

Jurisdiction has the same geographical meaning as in Bureau of Indian Affairs usage.

Service means the Indian Health Service.

§ 136.2 Purpose of the regulations.

The regulations in this part establish general principles and program requirements for carrying out the Indian health programs.

§ 136.3 Administrative instructions.

The service periodically issues administrative instructions to its officers and employees, which are primarily found in the *Indian Health Service Manual* and the Area Office and program office supplements. These instructions are operating procedures to assist officers and employees in carrying out their responsibilities, and are not regulations establishing program requirements which are binding upon members of the general public.

Subpart B—What Services Are Available and Who Is Eligible To Receive Care?

SOURCE: 64 FR 58319, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§ 136.11 Services available.

(a) *Type of services that may be available.* Services for the Indian community served by the local facilities and program may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) *Where services are available.* Available services will be provided at hospitals and clinics of the Service, and at contract facilities (including tribal facilities under contract with the Service).

(c) *Determination of what services are available.* The Service does not provide the same health services in each area served. The services provided to any particular Indian community will depend upon the facilities and services available from sources other than the Service and the financial and personnel resources made available to the Service.

§ 136.12 Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided

pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

§ 136.13 [Reserved]

§ 136.14 Care and treatment of ineligible individuals.

(a) In case of an emergency, as an act of humanity, individuals not eligible under § 136.12 may be provided temporary care and treatment in Service facilities.

(b) Charging ineligible individuals. Where the Service Unit Director determines that an ineligible individual is able to defray the cost of care and treatment, the individual shall be charged at rates approved by the Assistant Secretary for Health and Surgeon General published in the FEDERAL REGISTER. Reimbursement from third-party payors may be arranged by the patient or by the Service on behalf of the patient.

[64 FR 58319, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

Subpart C—Contract Health Services

SOURCE: 64 FR 58320, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§ 136.21 Definitions.

(a) *Alternate resources* is defined in § 136.61 of subpart G of this part.

(b) *Appropriate ordering official* means, unless otherwise specified by contract with the health care facility or provider, the ordering official for the contract health service delivery area in which the individual requesting contract health services or on whose behalf the services are requested, resides.

(c) *Area Director* means the Director of an Indian Health Service Area designated for purposes of administration of Indian Health Service programs.

(d) *Contract health service delivery area means* the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community who reside in the area, subject to the provisions of this subpart.

(e) *Contract health services* means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service.

(f) *Emergency* means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual.

(g) *Indian tribe* means any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(h) *Program Director* means the Director of an Indian Health Service ''program area'' designated for the purposes of administration of Indian Health Service programs.

(i) *Reservation* means any federally recognized Indian tribe's reservation. Pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 *et seq.*), and Indian allotments.

(j) *Secretary* means the Secretary of Health and Human Services to whom the authority involved has been delegated.

(k) *Service* means the Indian Health Service.

(l) *Service Unit Director* means the Director of an Indian Health Service ''Service unit area'' designated for purposes of administration of Indian Health Service programs.

[64 FR 58320, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

§ 136.22 Establishment of contract health service delivery areas.

(a) In accordance with the congressional intention that funds appropriated for the general support of the health program of the Indian Health

Service be used to provide health services for Indians who live on or near Indian reservations, contract health service delivery areas are established as follows:

(1) The State of Alaska;

(2) The State of Nevada;

(3) the State of Oklahoma;

(4) Chippewa, Mackinac, Luce, Alger, Schoolcraft, Delta, and Marquette Counties in the State of Michigan;

(5) Clark, Eau Claire, Jackson, La Crosse, Monroe, Vernon, Crawford, Shawano, Marathon, Wood, Juneau, Adams, Columbia, and Sauk Counties in the State of Wisconsin and Houston County in the State of Minnesota;

(6) With respect to all other reservations within the funded scope of the Indian health program, the contract health services delivery area shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation.

(b) The Secretary may from time to time, redesignate areas or communities within the United States as appropriate for inclusion or exclusion from a contract health service delivery area after consultation with the tribal governing body or bodies on those reservations included within the contract health service delivery area. The Secretary will take the following criteria into consideration:

(1) The number of Indians residing in the area proposed to be so included or excluded;

(2) Whether the tribal governing body has determined that Indians residing in the area near the reservation are socially and economically affiliated with the tribe;

(3) The geographic proximity to the reservation of the area whose inclusion or exclusion is being considered; and

(4) The level of funding which would be available for the provision of contract health services.

(c) Any redesignation under paragraph (b) of this section shall be made in accordance with the procedures of the Administrative Procedure Act (5 U.S.C. 553).

§ 136.23 Persons to whom contract health services will be provided.

(a) *In general.* To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available, to persons described in and in accordance with § 136.12 of this part if those persons:

(1) Reside within the United States and on a reservation located within a contract health service delivery area; or

(2) Do not reside on a reservation but reside within a contract health service delivery area and:

(i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established; or

(ii) Maintain close economic and social ties with that tribe or tribes.

(b) *Students and transients.* Subject to the provisions of this subpart, contract health services will be made available to students and transients who would be eligible for contract health services at the place of their permanent residence within a contract health service delivery area, but are temporarily absent from their residence as follows:

(1) Student—during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks (such as vacations, semester or other scheduled breaks occurring during their attendance) and for a period not to exceed 180 days after the completion of the course of study.

(2) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers) during their absence.

(c) *Other persons outside the contract health service delivery area.* Persons who leave the contract health service delivery area in which they are eligible for contract health service and are neither students nor transients will be eligible for contract health service for a period not to exceed 180 days from such departure.

(d) *Foster children.* Indian children who are placed in foster care outside a contract health service delivery area

by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care.

(e) *Priorities for contract health services.* When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

(f) *Alternate resources.* The term ''alternate resources'' is defined in §136.61(c) of subpart G of this part.

[64 FR 58319, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

§136.24 Authorization for contract health services.

(a) No payment will be made for medical care and services obtained from non-Service providers or in non-Service facilities unless the applicable requirements of paragraphs (b) and (c) of this section have been met and a purchase order for the care and services has been issued by the appropriate ordering official to the medical care provider.

(b) In nonemergency cases, a sick or disabled Indian, an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services notify the appropriate ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility. The requirement for notice prior to providing medical care and services under this paragraph may be waived by the ordering official if:

(1) Such notice and information are provided within 72 hours after the beginning of treatment or admission to a health care facility; and

(2) The ordering official determines that giving of notice prior to obtaining the medical care and services was impracticable or that other good cause exists for the failure to provide prior notice.

(c) In emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall within 72 hours after the beginning of treatment for the condition or after admission to a health care facility notify the appropriate ordering official of the fact of the admission or treatment, together with information necessary to determine the relative medical need for the services and the eligibility of the Indian for the services. The 72-hour period may be extended if the ordering official determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to comply.

§136.25 Reconsideration and appeals.

(a) Any person to whom contract health services are denied shall be notified of the denial in writing together with a statement of the reason for the denial. The notice shall advise the applicant for contract health services that within 30 days from the receipt of the notice the applicant:

(1) May obtain a reconsideration by the appropriate Service Unit Director of the original denial if the applicant submits additional supporting information not previously submitted; or

(2) If no additional information is submitted, may appeal the original denial by the Service Unit Director to the appropriate Area or program director. A request for reconsideration or appeal shall be in writing and shall set forth the grounds supporting the request or appeal.

(b) If the original decision is affirmed on reconsideration, the applicant shall be so notified in writing and advised that an appeal may be taken to the Area or program director within 30 days of receipt of the notice of the reconsidered decision. The appeal shall be in writing and shall set forth the grounds supporting the appeal.

(c) If the original or reconsidered decision is affirmed on appeal by the Area or program director, the applicant shall be so notified in writing and advised that a further appeal may be taken to the Director, Indian Health Service, within 30 days of receipt of the notice. The appeal shall be in writing and shall set the grounds supporting the appeal. The decision of the Director, Indian Health Service, shall constitute final administrative action.

Subpart D—Limitation on Charges for Services Furnished by Medicare-Participating Hospitals to Indians

SOURCE: 72 FR 30710, June 4, 2007, unless otherwise noted.

§ 136.30 Payment to Medicare-participating hospitals for authorized Contract Health Services.

(a) *Scope.* All Medicare-participating hospitals, which are defined for purposes of this subpart to include all departments and provider-based facilities of hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act), that furnish inpatient services must accept no more than the rates of payment under the methodology described in this section as payment in full for all items and services authorized by IHS, Tribal, and urban Indian organization entities, as described in paragraph (b) of this section.

(b) *Applicability.* The payment methodology under this section applies to all levels of care furnished by a Medicare-participating hospital, whether provided as inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is authorized under part 136, subpart C by a contract health service (CHS) program of the Indian Health Service (IHS); or authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Pub. L. 93–638, 25 U.S.C. 450 *et seq.;* or authorized for purchase under § 136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter ''I/T/U'').

(c) *Basic determination.* (1) Payment for hospital services that the Medicare program would pay under a prospective payment system (PPS) will be based on that PPS. For example, payment for inpatient hospital services shall be made per discharge based on the applicable PPS used by the Medicare program to pay for similar hospital services under 42 CFR part 412. Payment for outpatient hospital services shall be made based on a PPS used in the Medicare program to pay for similar hospital services under 42 CFR part 419. Payment for skilled nursing facility (SNF) services shall be based on a PPS used in the Medicare program to pay for similar SNF services under 42 CFR part 413.

(2) For Medicare participating hospitals that furnish inpatient services but are exempt from PPS and receive reimbursement based on reasonable costs (for example, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements), including provider subunits exempt from PPS, payment shall be made per discharge based on the reasonable cost methods established under 42 CFR part 413, except that the interim payment rate under 42 CFR part 413, subpart E shall constitute payment in full for authorized charges.

(d) *Other payments.* In addition to the amount payable under paragraph (c)(1) of this section for authorized inpatient services, payments shall include an amount to cover: The organ acquisition costs incurred by hospitals with approved transplantation centers; direct medical education costs; units of blood clotting factor furnished to an eligible patient who is a hemophiliac; and the costs of qualified non-physician anesthetists, to the extent such costs would be payable if the services had been covered by Medicare. Payment under this subsection shall be made on a per discharge basis and will be based on standard payments established by the Centers for Medicare & Medicaid Services (CMS) or its fiscal intermediaries.

(e) *Basic payment calculation.* The calculation of the payment by I/T/Us will be based on determinations made under paragraphs (c) and (d) of this section consistent with CMS instructions to its fiscal intermediaries at the time the claim is processed. Adjustments will be made to correct billing or claims processing errors, including when fraud is detected. I/T/Us shall pay the providing hospital the full PPS based rate, or the interim reasonable cost rate, without

reduction for any co-payments, coinsurance, and deductibles required by the Medicare program from the patient.

(f) *Exceptions to payment calculation.* Notwithstanding paragraph (e) of this section, if an amount has been negotiated with the hospital or its agent by the I/T/U, the I/T/U will pay the lesser of: The amount determined under paragraph (e) of this section or the amount negotiated with the hospital or its agent, including but not limited to capitated contracts or contracts per Federal law requirements;

(g) *Coordination of benefits and limitation on recovery.* If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payor—

(1) The I/T/U shall be the payor of last resort under § 136.61;

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider of services has coordinated benefits and all other alternative resources have been considered and paid, including applicable copayments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payor; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (e) of this section or the contracted amount (plus applicable cost sharing), whichever is less; and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid (except for applicable cost sharing).

(h) *Claims processing.* For a hospital to be eligible for payment under this section, the hospital or its agent must submit the claim for authorized services—

(1) On a UB92 paper claim form (until abolished, or on an officially adopted successor form) or the HIPAA 837 electronic claims format ANSI X12N, version 4010A1 (until abolished, or on an officially adopted successor form) and include the hospital's Medicare provider number/National Provider Identifier; and

(2) To the I/T/U, agent, or fiscal intermediary identified by the I/T/U in the agreement between the I/T/U and the hospital or in the authorization for services provided by the I/T/U; and

(3) Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the Medicare Claims Processing Manual applicable to the type of item or service provided.

(i) *Authorized services.* Payment shall be made only for those items and services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, as amended, 25 U.S.C. 1653(a).

(j) *No additional charges.* A payment made in accordance with this section shall constitute payment in full and the hospital or its agent may not impose any additional charge—

(1) On the individual for I/T/U authorized items and services; or

(2) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

§ 136.31 Authorization by urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by Medicare-participating inpatient hospitals shall be subject to the payment methodology set forth in § 136.30.

§ 136.32 Disallowance.

(a) If it is determined that a hospital has submitted inaccurate information for payment, such as admission, discharge or billing data, an I/T/U may as appropriate—

(1) Deny payment (in whole or in part) with respect to any such services, and;

(2) Disallow costs previously paid, including any payments made under any methodology authorized under this subpart. The recovery of payments

made in error may be taken by any method authorized by law.

(b) For cost based payments previously issued under this subpart, if it is determined that actual costs fall significantly below the computed rate actually paid, the computed rate may be retrospectively adjusted. The recovery of overpayments made as a result of the adjusted rate may be taken by any method authorized by law.

Subpart E—Preference in Employment

AUTHORITY: 25 U.S.C. 44, 45, 46 and 472; Pub. L. 83-568, 68 Stat 674, 42 U.S.C. 2003.

SOURCE: 64 FR 58321, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§ 136.41 Definitions.

For purposes of making appointments to vacancies in all positions in the Indian Health Service, a preference will be extended to persons of Indian descent who are:

(a) Members of any recognized Indian tribe now under Federal jurisdiction;

(b) Descendants of such members who were, on June 1, 1934, residing within the present boundaries of any Indian reservation;

(c) All others of one-half or more Indian blood of tribes indigenous to the United States;

(d) Eskimos and other aboriginal people of Alaska; or

(e) Until January 4, 1990, or until the Osage Tribe has formally organized, whichever comes first, a person of at least one-quarter degree Indian ancestry of the Osage Tribe of Indians, whose rolls were closed by an act of Congress.

§ 136.42 Appointment actions.

(a) Preference will be afforded a person meeting any one of the definitions of § 136.41 whether the placement in the position involves initial appointment, reappointment, reinstatement, transfer, reassignment, promotion, or any other personnel action intended to fill a vacancy.

(b) Preference eligibles may be given a schedule A excepted appointment under 5 CFR 213.3116(b)(8). If the individuals are within reach on a Civil Service Register, they may be given a competitive appointment.

[64 FR 58321, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

§ 136.43 Application procedure for preference eligibility.

To be considered a preference eligible, the person must submit with the employment application a Bureau of Indian Affairs certification that the person is an Indian as defined by § 136.41 except that an employee of the Indian Health Service who has a certificate of preference eligibility on file in the Official Personnel Folder is not required to resubmit such proof but may instead include a statement on the application that proof of eligibility is on file in the Official Personnel Folder.

[64 FR 58319, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

Subpart F—Abortions and Related Medical Services in Indian Health Service Facilities and Indian Health Service Programs

AUTHORITY: Sec. 1, 42 Stat. 208, (25 U.S.C. 13); sec. 1, Stat. 674, (42 U.S.C. 2001); sec. 3, 68 Stat. 674, (42 U.S.C. 2003).

SOURCE: 64 FR 58322, Oct. 28, 1999, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§ 136.51 Applicability.

This subpart is applicable to the use of Federal funds in providing health services to Indians in accordance with the provisions of subparts A, B, and C of this part.

§ 136.52 Definitions.

As used in this subpart:

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery at an Indian Health Service or tribally run facility, or by the state in which he or she practices.

§ 136.53 General rule.

Federal funds may not be used to pay for or otherwise provide for abortions

in the programs described in §136.51, except under the circumstances described in §136.54.

[64 FR 58322, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

§136.54 Life of the mother would be endangered.

Federal funds are available for an abortion when a physician has found and so certified in writing to the appropriate tribal or other contracting organization, or Service Unit or Area Director, that ''on the basis of my professional judgment the life of the mother would be endangered if the fetus were carried to term.'' The certification must contain the name and address of the patient.

§136.55 Drugs and devices and termination of ectopic pregnancies.

Federal funds are available for drugs or devices to prevent implantation of the fertilized ovum, and for medical procedures necessary for the termination of an ectopic pregnancy.

§136.56 Recordkeeping requirements.

Documents required by §136.54 must be maintained for three years pursuant to the retention and custodial requirements for records at 45 CFR part 74, subpart C.

[64 FR 58322, Oct. 28, 1999. Redesignated and amended at 67 FR 35342, May 17, 2002]

§136.57 Confidentiality.

Information which is acquired in connection with the requirements of this subpart may not be disclosed in a form which permits the identification of an individual without the individual's consent, except as may be necessary for the health of the individual or as may be necessary for the Secretary to monitor Indian Health Service program activities. In any event, any disclosure shall be subject to appropriate safeguards which will minimize the likelihood of disclosures of personal information in identifiable form.

Subpart G—Residual Status

§136.61 Payor of last resort.

(a) The Indian Health Service is the payor of last resort for persons defined as eligible for contract health services under the regulations in this part, notwithstanding any State or local law or regulation to the contrary.

(b) Accordingly, the Indian Health Service will not be responsible for or authorize payment for contract health services to the extent that:

(1) The Indian is eligible for alternate resources, as defined in paragraph (c) of this section, or

(2) The Indian would be eligible for alternate resources if he or she were to apply for them, or

(3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the Indian Health Service or Indian Health Service funded programs.

(c) *Alternate resources* means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (*i.e.*, Medicare, Medicaid), State or local health care programs, and private insurance.

[64 FR 58322, Oct. 28, 1999]

Subpart H—Grants for Development, Construction, and Operation of Facilities and Services

AUTHORITY: Secs. 104, 107, 25 U.S.C. 450h(b), 450k; Sec. 3, Pub. L. 83-568, 42 U.S.C. 2003.

SOURCE: 40 FR 53143, Nov. 14, 1975, unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

§136.101 Applicability.

The regulations of this subpart are applicable to grants awarded pursuant to section 104(b) of Pub. L. 93-638, 25 U.S.C. 450h(b) for (a) projects for development including feasibility studies, construction, operation, provision, or maintenance of services and facilities provided to Indians and, (b) for projects for planning, training, evaluation or other activities designed to improve the capacity of a tribal organization to