Attachment 2a
Initial 60-Day Notice

March 12, 2009

transnational referral. Modifications include updates to drug regimens and drug susceptibility tests. Date of death and whether TB was a cause of death were added to status at diagnosis. Major site and additional sites of TB disease were combined to a single question. Smear, pathology, or cytology now capture histology results in addition to microbiology, and a single field for anatomic specimen code replaced two codes for positive specimens. Initial chest radiograph or other chest imaging was updated to capture whether an abnormal chest image shows a cavity or miliary TB, replacing miliary as a site of disease and simplifying check boxes for radiograph as cavitary, consistent with TB, stable, worsening, improving, or unknown. Whether patients were under custody of Immigration and Customs Enforcement was added to the correctional facility variable, and occupation was modified to capture the past year, with check boxes to differentiate persons not eligible for employment from the unemployed. Type of health care provider was clarified with categories of outpatient care. Reasons for culture conversion not being documented were incorporated, and adverse treatment event and death were added as reasons TB therapy stopped or never started. Deletions include removal of: (1) Soundex, a software code; (2) a text field to indicate who submitted the RVCT; (3) a check box asking whether the case was anergic; (4) CDC AIDS patient number; (5) how HIV positive status was determined; (6) a check box for more than one additional site of TB disease; and (7) site of directly observed therapy. DTBE is currently working with stakeholders and software team members towards development and implementation of an updated software module for the transition from the current software for RVCT data entry and electronic transmission of reports to CDC to collection and reporting of revised RVCT data. Following the transition, respondents will be able to use either the CDC associated TB module or their own TB surveillance application to collect and report RVCT data to CDC. CDC publishes an annual report using RVCT data to summarize national TB statistics and also periodically conducts special analyses for publication to further describe and interpret national TB data. These data assist in public health planning, evaluation, and resource allocation. Reporting areas also review and analyze their RVCT data to monitor local TB trends, evaluate program success, and focus resources to eliminate TB. No other Federal agency collects this type of national TB data. In addition to providing technical assistance on the use of RVCT, CDC provides technical support for reporting software. In this request, CDC is requesting approval for approximately 8050 burden hours, an estimated increase of 490 hours. This increase is due to the addition of information on new clinical diagnostic tests and factors to identify high-risk patients. There is no cost to respondents other than their time to participate in the survey.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Types of respondents	Number of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Local, state, and territorial health departments	60	230	35/60	8050

Dated: July 26, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–07–07BI]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 and send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Rapid HIV Testing in Community Mental Health Settings Serving African Americans—New—National Center for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

People with chronic mental illness, including those with substance use disorders, are at increased risk of HIV infection compared with the general population. However, not enough is known about the risk behaviors, willingness to be tested for HIV, and HIV prevalence among persons with chronic mental illness. In addition, the interrelations among diagnosis of HIV infection, compliance with medical care, subsequent risk behaviors, and the course of mental illness have not been well-described. Mental health clinics are an important setting for HIV rapid testing and promoting prevention efforts against the transmission of HIV infection.

The objectives of this project are to (1) increase the number of mental health providers who routinely provide HIV counseling, testing, and linkage to care in settings that provide mental health care, especially those serving African American communities; and (2) describe the relationship between mental illness,

HIV risk behaviors, and access to HIV testing and services, in order to inform the development of optimal HIV prevention interventions for persons with chronic mental illness, and particularly for African Americans with chronic mental illness. Staff at selected implementation sites will routinely offer counseling and rapid HIV testing to clients and administer a brief survey to assess HIV risk behaviors, previous access to HIV testing and services, and mental health symptoms. Collection of data from client medical records will provide information on diagnoses, clinical course, and treatment history. Clients who enroll will be followed longitudinally with a follow-up survey offered at 6-month intervals and repeat rapid HIV testing offered annually.

This project will collect data from clients using brief surveys administered on a voluntary basis. Collection of data will provide information on client demographics; current behaviors that may facilitate HIV transmission, including sexual and drug-use behaviors; current psychiatric symptoms, determined using brief rating scales; access and barriers to HIV testing, prevention, and treatment services; and adherence to psychiatric and medical treatment regimens. CDC is requesting approval for a 3-year clearance for data collection. Data will be collected in 4 community mental health sites. CDC estimates that an average of 900 clients will be asked to participate at each site annually and that 80% will accept, resulting in 2,880 new survey respondents each year across all sites. The average duration of the initial survey is estimated to be 45 minutes. CDC estimates an 80% acceptance rate at 6-month follow-up among the initial 2,880 respondents, resulting in 2,304 respondents for the follow-up survey at 6-month intervals and an average of 4,608 follow-up respondents per year over the course of the project. The average duration of the follow-up survey is estimated to be 30 minutes. Participation is voluntary. Data collection will provide important insights into the relationship between HIV risk behaviors and psychiatric illness. There is no cost to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of form	Average number of respondents per annum	Average number of responses per respondent	Average burden per response (Hours)	Total burden per annum (Hours)
Clinic Patient Initial Survey	2,880	1	45/60	2,160
Clinic Patient Follow-up Survey	4,608	2	30/60	4,608
Total				6,768

Dated: July 26, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Reallotment of FY 2006 Funds for the Low Income Home Energy Assistance Program (LIHEAP)

AGENCY: Office of Community Services, ACF, HHS.

ACTION: Notice of determination concerning funds available for reallotment.

CFDA Number: 93.568

SUMMARY: Notice is hereby given of a preliminary determination that funds from the fiscal year (FY) 2006 Low Income Home Energy Assistance Program (LIHEAP) are available for reallotment to States, Territories, and Tribes and Tribal Organizations that receive FY 2007 direct LIHEAP grants. No subgrantees or other entities may apply for these funds. Section 2607(b)(1) of the Low Income Home Energy Assistance Act (the Act), Title XXVI of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 8621 *et seq.*), as amended, requires that if the Secretary of the Department of Health and Human Services (HHS) determines that, as of September 1 of any fiscal year, an amount in excess of certain levels allotted to a grantee for any fiscal year will not be used by the grantee during the fiscal year, the Secretary must notify the grantee and publish a notice in the **Federal Register** that such funds may be realloted to LIHEAP grantees during the following fiscal year. If reallotted, the LIHEAP block grant allocation formula will be used to distribute the funds. (No funds may be allotted to entities that are not direct LIHEAP grantees during FY 2007.) It has been determined that $326,894 may be available for reallotment during FY 2007. This determination is based on revised Carryover and Reallotment Reports from the Turtle Mountain Band of Chippewa Indians in North Dakota and Southern Ute Indian Tribe in Colorado, which were submitted to the Office of Community Services as required by 45 CFR 96.82.

The statute allows grantees who have funds unobligated at the end of the fiscal year for which they are awarded to request that they be allowed to carry over up to 10 percent of their allotments to the next fiscal year. Funds in excess of this amount must be returned to HHS and are subject to reallotment under section 2607(b)(1) of the Act. The amount described in this notice was reported as unobligated FY 2006 funds in excess of the amount that the Turtle Mountain Band of Chippewa Indians could carry over to FY 2007. Additionally, an amount from Southern Ute Indian Tribe is excess funds for FY 2006 plus the 10 percent carryover, since the tribe did not apply for FY 2007 LIHEAP funds.

The Turtle Mountain Band of Chippewa Indians was notified by certified mail that $297,492 of its FY 2006 funds may be reallotted. Additionally, the Southern Ute Indian Tribe was notified by certified mail that $29,402 of its FY 2006 funds may be reallotted. In accordance with section 2607(b)(3), the Chief Executive Officers of both the tribes have 30 days from the date of the letter to submit comments to: Josephine B. Robinson, Director, Office of Community Services, 370 L'Enfant Promenade, SW., Washington, DC 20447.

The comment period expires August 31, 2007.

After considering any comments submitted, the Chief Executive Officers will be notified of the final reallotment amount, and this decision also will be published in the **Federal Register**. If funds are reallotted, they will be