

Awardee Lead Profile Assessment (ALPA)

OMB Control No. 0920-1215, Expiration Date 05/31/2026

REVISION

Supporting Statement Part A –

Justification

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Part A. Justification

Goal of the study: The purpose of this annual assessment under the cooperative agreement is to collect information from CDC funded programs. Information will be collected on childhood lead poisoning-related laws and guidance, surveillance, prevention strategies, and at what blood lead levels various case management activities are performed.

Intended use of the resulting data: CDC can use this information to inform guidance, resource development, and technical assistance to support eliminating lead exposure in children. CDC will share findings with funded Childhood Lead Poisoning Prevention Programs (CLPPPs) and in response to inquiries by the public, press, and Congress; a report or journal article may be published. Funded and non-funded programs can use results to 1) identify policies and strategies that support or hinder childhood lead poisoning prevention efforts and 2) develop and implement similar interventions to improve childhood lead poisoning prevention.

Methods to be used to collect: Data will be collected annually from the project managers of funded CLPPPs using a web-based information collection instrument (REDCap).

Populations to be studied: Up to 50 states and up to 25 tribal, local and territorial CLPPPs as well as the District of Columbia that receive CDC funding from CDC for childhood lead poisoning prevention (n=75).

How data will be analyzed: CDC staff will use Excel, Power BI and/or other statistical software programs to calculate and organize descriptive statistics and qualitative response themes.

A.1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention (CDC) is requesting approval for revision to an approved information collection. CDC requests this data collection approval for three years. This data collection will help CDC better understand how funded programs address childhood lead poisoning. It will also provide insight into which laws, guidance, surveillance, prevention strategies, and case management activities are most effective. Information will be used to improve guidance, resources, and technical assistance to eliminate lead exposure in children.

Health Impacts

Lead is highly toxic, and no safe level of exposure has been identified. Even low levels can harm health, especially in young children. Lead exposure can damage the developing brain and nervous system resulting in learning difficulties, behavioral issues, and reduced academic achievement. In severe cases, lead poisoning can be fatal.

Children under age six are at greatest risk due to their rapid development and behaviors such as hand-to-mouth activity. Despite progress in reducing exposure, an estimated 535,000 U.S.

children ages 1–5 still have blood lead levels (BLLs) at or above CDC’s blood lead reference value (BLRV) of 3.5 µg/dL (Ruckart et al, 2021).

Sources of Exposure

Although banned for residential use in 1978, nearly 30% of U.S. homes still contain lead-based paint (HUD, 2022). When this paint deteriorates, it can create lead-contaminated dust. Lead contaminated soil and drinking water are also common sources in the U.S. Additional sources of exposure include lead-contaminated toys, jewelry, traditional remedies, food, and ceramics. Exposure can also occur from occupational or hobby-related activities involving lead.

Need for Collection

Federal legislation, including the Lead Contamination Control Act (Attachment 1), authorizes CDC to support programs that prevent and control childhood lead poisoning. CDC’s Lead Poisoning Prevention and Surveillance (LPPS) Branch within the National Center for Environmental Health (NCEH) supports state, tribal, local, and territorial health departments through cooperative agreements to strengthen blood lead testing, reporting, surveillance, follow-up care, and targeted prevention. In addition, Section 2204 of the Water Infrastructure Improvements for the Nation (WIIN) Act of 2016 [Public Law No: 114-322] tasks CDC with enhancing childhood lead poisoning prevention activities.

This data collection is supported under (CDC-RFA-EH21-2102) and aligns with national public health priorities, including Healthy People 2030 goals to reduce children’s BLLs and overall lead exposure. The 60-day Federal Register Notice (Attachment 2) was published on 1/13/2026 and is further discussed in Section A.8.

A.2. Purpose and Use of the Information Collection

The purpose of this information collection is program management and evaluation by collecting information from CDC-funded programs on how they address childhood lead poisoning. CDC will use findings to identify opportunities and challenges, understand which strategies are effective, and share best practices more broadly. Both funded and non-funded programs can use these insights to strengthen their efforts.

The details of the proposed revisions to this ICR are discussed in Section A.15, and are summarized here:

- The electronic data collection tool was updated to REDCap because Epi Info is no longer available at CDC. Using REDCap improves functionality and streamline data management.
- The section on local laws was removed to focus solely on programs receiving surveillance funding, ensuring greater relevance and consistency across respondents.
- Questions that were unclear or difficult to interpret were revised for clarity.

- Redundant or overlapping questions and response choices were combined where appropriate for clarity and to reduce respondent burden.
- The previous alphanumeric question labels were replaced with a fully numeric system, creating a cleaner and more organized survey format.

Data will be used to assess: (1) BLLs that prompt public health action; (2) lead poisoning prevention program successes; (3) gaps, barriers, and opportunities for program effectiveness; and (4) proven resources to eliminate childhood lead poisoning. Data will primarily be used internally to monitor program impact. Results may also be shared with CDC-funded programs, used to respond to inquiries, and included in reports or publications.

A.3. Use of Improved Information Technology and Burden Reduction

Data will be collected electronically via a web-based REDCap survey (Attachment 4). This method was selected to minimize the burden on respondents and requires no special technical expertise or proprietary software. The survey is designed to gather only the essential information needed for this information collection.

A.4. Efforts to Identify Duplication and Use of Similar Information

There are no existing data systems or publicly available sources that collect the information required for this proposed information collection. This effort is necessary to meet federal reporting requirements for funded programs and to obtain consistent, program-specific information on childhood lead poisoning prevention activities. LPPS previously consulted with the National Center for Health Statistics (NCHS) and the following national public health organizations to ensure that this collection does not duplicate existing efforts: Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH).

These consultations, along with internal review, confirmed that the information is not systematically collected elsewhere. Additionally, this information is not available through any publicly accessible database. Therefore, this information collection is necessary to support program monitoring, evaluation, and improvement.

A.5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses.

A.6. Consequences of Collecting the Information Less Frequently

Currently, CDC requests that funded programs provide these data once per year. Consequences of reducing this frequency would be the loss of monitoring program activities and the inability to provide relevant guidance on lead poisoning prevention on an annual basis.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

- A. A 60-day Federal Register Notice will be published in the *Federal Register* on 1/13/2026, vol 91, No. 8, pp. 1324-1325(Attachment 2). CDC/ATSDR did not receive public comments related to this notice.
- B. CDC did not consult any persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions, and record keeping, disclosure, or reporting format.

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

On March 10, 2023, the NCEH/ATSDR System Security and Privacy Officer (SSPO) concluded that the Privacy Act does not apply to ALPA because it does not collect any personally identifiable or sensitive information. ALPA gathers data specifically about childhood lead poisoning prevention programs ("entities"), rather than information about individuals.

On April 7, 2026, the NCEH/ATSDR SSPO reviewed the revised Information Collection Request (ICR) and confirmed that a new Privacy Threshold Analysis (PTA (Attachment 5)) is not required.

Security controls are adequate for protecting the aggregated and non-sensitive data being collected using Redcap, an authorized CDC survey system.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

No personal or sensitive data will be collected. The NCEH/ATSDR Human Subjects Contact has determined that the data collection is being conducted for program evaluation and quality improvement purposes and is not research. IRB approval is not required (Attachment 8).

This information will be collected to fulfill the non-research program requirements under current and future NOFOs. Participation is required for satisfactory performance.

A.12. Estimates of Annualized Burden Hours and Costs

a) Estimated annualized burden hours

Data will be collected from up to 75 respondents - specifically, lead poisoning prevention program project managers of state, tribal, local, and territorial governments.

The estimate for burden hours for the revised ALPA is based on pilot testing of a draft revised ALPA survey in 2025. We estimate that it will take 53 minutes to respond. The total annual time for respondents is expected to be 66 hours.

Table 1: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State, Tribal, Local, and Territorial Governments	ALPA Web Survey	75	1	53/60	66
Total					66

b) Estimated annualized cost to respondents

Estimates for the average hourly wage for respondents are based on the Bureau of Labor Statistics Occupational Employment and Wages, May 2024, for Medical and Health Services Managers (<https://www.bls.gov/oes/current/oes119111.htm>). Based on DOL data, an average hourly wage of \$66.22 is estimated for all respondents. Table 2 (below) shows estimated annualized burden costs.

Occupation Code & Title	Job Description
11-9111 – Medical and Health Services Managers	Plan, direct, or coordinate medical and health services in hospitals, clinics, managed care organizations, public health agencies, or similar organizations.

Table 2: Estimated Annualized Burden Costs

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Hourly Wage Rate	Total Costs
State, Tribal, Local, and Territorial,	ALPA Web Survey	75	1	53/60	\$66.22	\$4,387.08

Governments						
Total						\$4,387.08

A.13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

There will be no direct costs to the respondents other than their time to participate in the information collection.

A.14. Annualized Cost to the Federal Government

The annualized cost to the federal government for ALPA is \$1,741,204, and is based on the following:

- The annual FY25 cooperative agreement program budget for lead poisoning prevention activities is estimated to be \$705,000.
 - This cooperative agreement cost is based on the five-year FY25 program budget of almost \$141,000,000 (Attachment 3).
 - One-half of the program budget is estimated to support program management, and one half of the program budget is estimated to support lead poisoning prevention activities. This is \$70,500,000 per program area for five years, or \$141,000,000 per year.
 - We estimate that 95% of the annual cooperative agreement management activities will be related to performance measures (\$13,395,000), while 5% of the annual cooperative agreement management will be attributed to activities related to the ALPA survey (\$705,000).
- The annual federal personnel salary cost for lead poisoning prevention activities is \$1,036,204.
 - This salary estimate is based on a total annual cost of \$1,727,007 for the following positions: Branch Chief, Deputy Branch Chief, six Project Officers, and two Health Scientists¹. Overall, 60% LPPS personnel time is dedicated to cooperative agreement management (\$1,036,204) and 40% is dedicated to lead poisoning prevention activities (\$690,803).
- There are no annual travel or contract costs related to the ALPA collection.

A.15. Explanation for Program Changes or Adjustments

The details of the proposed revisions to this ICR are summarized here.

¹ Based on OPM Atlanta Locality Pay for Grade and Step 5 Salary Table at <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/20Tables/html/ATL.aspx>.

- The electronic data collection tool was updated from Epi Info to REDCap to improve functionality and streamline data management.
- The section on local laws was removed to focus solely on programs receiving surveillance funding, ensuring greater relevance and consistency.
- Questions were revised to clarify those that were unclear or difficult to interpret.
- Redundant or overlapping questions and response choices were combined where appropriate for clarity and to reduce respondent burden.
- The previous alphanumeric question labels were replaced with a fully numeric system, creating a cleaner and more organized survey format.

The time estimate per response is based on pilot tests of the revised survey among 5 respondents, and includes the time needed to review the ALPA user guide. The revised survey is an average burden of 53 minutes for each respondent.

Table 3: Changes to the online ALPA Survey

Original Question No.	Original Question	Suggested Revision	New Question No.
1	Agree to participate in the survey	Included as part of REDCap to be able to start survey	
2	Program Title	What is your Program Title (ex. State Childhood Lead Poisoning Prevention Program, NYC Health Dept)	1
3	City of Program Headquarters	What city is your program headquarters	2
4	State or Territory of Program Headquarters	Select the State/Territory Program Headquarters	3
		Add question “Which best describes your program?”	4
5a	Does your jurisdiction have state or territorial legislation mandating blood lead testing for Medicaid-enrolled children?	What is your program strategy for blood lead testing for children enrolled in Medicaid?	5
5b	What strategy is the mandate based on?	Question is combined with previous question	
		If no is selected for question 5 new question “Why doesn't your program mandate universal testing for all children enrolled in Medicaid?”	6
5c	Please specify the ages covered by your jurisdiction’s legislation.	What ages are covered by your program’s strategy for children enrolled in Medicaid?	7
6a	Does your jurisdiction have state or territorial legislation mandating	What is your program’s strategy for blood lead testing for children not	8

	blood lead testing for non-Medicaid-enrolled children?	enrolled in Medicaid?	
6b	What strategy is the mandate based on?	Question is combined with previous question	
6c	Please specify the ages covered by your jurisdiction's legislation.	What ages are covered by your program's strategy for children not enrolled in Medicaid?	9
7a	Does your state or territorial jurisdiction have legislation mandating blood lead testing for pregnant women?	Does your program have a strategy for blood lead testing for pregnant women?	10
7b	What strategy is the mandate based on?	What is the strategy based on?	11
8	Does your jurisdiction have state or territorial legislation mandating the existence or operation of a program?	Does your program have legislation mandating the existence or operation of a program?	12
9	Does your jurisdiction have a state or territorial reporting law for blood lead levels in children?	Does your program have a reporting law for blood lead levels in children ?	13
9a	Please specify the ages covered by your jurisdiction's blood lead level reporting law.	What ages are covered by your program's blood lead level reporting law?	14
9b	Please specify which blood lead levels are required to be reported. (Select one)	Which blood lead levels are required to be reported? (Select one)	15
9c	Please specify who is mandated to report the blood lead levels. (Select all that apply)	Who is mandated to report the blood lead levels to your program? (Select all that apply)	16
10	Does your jurisdiction have a state or territorial <u>electronic health data</u> reporting law?	Does your program require electronic reporting for blood lead levels?	17
11	Does your jurisdiction have a state or territorial lead paint abatement and/or remediation law(s)?	Does your program have a lead paint abatement and/or remediation law(s)?	18
11a	What strategy(s) is the law(s) based on? (Select all that apply)	Which of the following does the law apply to? (Select all that apply)	19
11b	What triggers the law(s)? (Select all that apply)	What triggers the law(s)? (Select all that apply)	20
11c	Please specify which age ranges trigger the law(s). (Select one)	This question was consolidated, and age ranges are part of question 20's responses	20
11d	Please specify which blood lead levels trigger the law(s). (Select one)	This question was consolidated, and blood lead levels are part of question 20's responses	20
12	Are you a local department or their bona fide agent?	Question removed (related to local laws)	
13	Do any of your jurisdiction's local legislations regarding childhood lead poisoning prevention differ from	Question removed (related to local laws)	

	your state legislations?		
14 a-c	Does your jurisdiction have local legislation mandating blood lead testing for <u>Medicaid-enrolled</u> children?	Question removed (related to local laws)	
15 a-c	Does your jurisdiction have local legislation mandating blood lead testing for <u>non-Medicaid-enrolled</u> children?	Question removed (related to local laws)	
16 a-b	Does your jurisdiction have local legislation mandating blood lead testing for pregnant women?	Question removed (related to local laws)	
17	Does your jurisdiction have local legislation mandating the existence or operation of a program?	Question removed (related to local laws)	
18	Does your jurisdiction have a local reporting law for blood lead levels in children?	Question removed (related to local laws)	
18a	Please specify the ages covered by your jurisdiction's blood lead level reporting law	Question removed (related to local laws)	
18b	Please specify which blood lead levels are required to be reported. (Select one)	Question removed (related to local laws)	
18c	Please specify who is mandated to report the blood lead levels. (Select all that apply)	Question removed (related to local laws)	
19	Does your jurisdiction have a local electronic health data reporting law?	Question removed (related to local laws)	
20	Does your jurisdiction have a local lead paint abatement and/or remediation law(s)?	Question removed (related to local laws)	
20a	What strategy(s) is the law(s) based on? (Select all that apply)	Question removed (related to local laws)	
20b	What triggers the law(s)? (Select all that apply)	Question removed (related to local laws)	
20c	Please specify which age ranges trigger the law(s). (Select one)	Question removed (related to local laws)	
20d	Please specify which blood lead levels trigger the law(s). (Select one)	Question removed (related to local laws)	
21	Regarding the blood lead levels at which various public health actions are initiated, has your jurisdiction decided to:	Does your program use CDC's blood lead reference value (BLRV) of 3.5 ug/dL for at least one public health action?	21
21a	When will this change be effective?	When did this change become effective? (MM/YYYY)	22
22	What barriers hinder your jurisdiction's ability to use the updated BLRV of 3.5 ug/dL to	What barriers hinder your program's ability to use CDC's current BLRV to initiate various	23

	initiate various public health actions?	public health actions? (Select all that apply)	
23	Over the past 12 months, what has been the general trend for blood lead testing rates in your jurisdiction?	Over the past 12 months, what has been the general trend for blood lead testing rates in the area covered by your program?	24
23a	If testing rates have increased in your jurisdiction, what do you attribute that change to?	If testing rates have increased, what do you attribute that change to?	25
23b	If testing rates have decreased in your jurisdiction, what do you attribute that change to?	If testing rates have decreased, what do you attribute that change to?	26
24a	For Medicaid-enrolled children less than 6 years (72 months) of age, does your jurisdiction <u>practice</u> a blood lead case management that is different from your jurisdiction's mandate?	Question removed	
24b	For Medicaid-enrolled children less than 6 years (72 months) of age, how does your jurisdiction <u>practice</u> a blood lead case management differ you're your jurisdiction's mandate? (select all that apply)	Question removed	
24c	For Medicaid-enrolled children less than 6 years (72 months) of age, what barriers does your jurisdiction face when <u>practicing</u> blood lead case management ? (Select all that apply)	Question removed	
25a	For non-Medicaid-enrolled children less than 6 years (72 months) of age, does your jurisdiction <u>practice</u> a blood lead case management that is different from your jurisdiction's mandate?	Question removed	
25b	For non-Medicaid-enrolled children less than 6 years (72 months) of age, how does your jurisdiction <u>practice</u> a blood lead case management differ you're your jurisdiction's mandate? (select all that apply)	Question removed	
25c	For non-Medicaid-enrolled children less than 6 years (72 months) of age, what barriers does your jurisdiction face when <u>practicing</u> blood lead case management ? (Select all that apply)	Question removed	
26	Does your program conduct any of the following primary prevention activities? (Select all that apply)	Does your program conduct any of the following primary prevention activities? (Select all that apply)	27

27	Has your jurisdiction's program developed a lead elimination plan or goal?	Does your program have an active lead elimination plan?	28
27a	Does your jurisdiction's lead elimination plan have any measures? (Select all that apply)	Does your program's lead elimination plan have any of the following measures? (Select all that apply)	29
27b	Does your jurisdiction's lead elimination plan include any of the following components? (Select all that apply)	Does your program's lead elimination plan include any of the following components? (Select all that apply)	30
28	Does your jurisdiction's program target high-risk areas and/or populations?	Question removed	
29	Does your jurisdiction publish GIS maps of high-risk areas and/or populations for public use?	Does your program publish maps of high risk areas and/or populations for public use?	31
		New question "Does your program have a public-facing interactive mapping tool?"	32
30a-h.	Administrative: at what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for lead in blood for children less than 6 years (72 months) of age?	This section is consolidated from 4 question to 2. Change questions from 30a-30f "phone call, mail letter and/or brochure, refer patients for services, begin coordination of services to 33a-b "Notification (Phone call, mail letter, provide educational materials)" Change question from 30g-h "begin coordination of services" to 33c-d "Begin case management or follow up"	33a-d.
31a-j	Assessment and Remediation of Residential Lead Exposure: at what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for lead in blood for children less than 6 years (72 months) of age?	This section is consolidated from 5 questions to 2. Change in questions includes from 31a-b. "Inspection of the child's home and other sites" 31c-d. "Obtain a history of the child's exposure to potential lead hazards" 31e-f. "Measure environmental lead levels in the home and other sites" 31g-h. "Educational interventions to reduce ongoing exposure" To 34a-b "Obtain child's exposure history/inspect child's home/measure environmental lead levels"	34a-d

		<p>Change from 31i-j. “Abatement interventions to reduce ongoing exposure”</p> <p>To 34c-d “Lead hazard reduction or abatement interventions to reduce exposure”</p>	
32a-t	<p>Medical Assessment and Interventions: at what confirmed blood lead level do you initiate the following actions according to your jurisdiction’s case definition for lead in blood for children less than 6 years (72 months) of age?</p>	<p>Removed question “caregiver lead education (nutritional and environmental)”</p> <p>Change question from 32c-d “follow-up blood lead monitoring and testing” to 35a-b “follow-up blood lead testing”</p> <p>Combined questions from 32e-f. “complete history and physical exam”, and 32g-h. “complete neurological exam” to 35c-d “Conduct history and physical exam/neurological exam/developmental assessment”</p> <p>Change question from 32i-j “Labwork (e.g. hemoglobin or hematocrit, iron status) to 35e-f “Additional lab work or diagnostic studies (e.g. hemoglobin or hematocrit, iron status, abdominal x-ray)”</p> <p>Remove question 32k-32l “Temporary measures for lead hazard reduction”</p> <p>Remove question 32m-32n. “permanent measures for lead hazard reduction”</p> <p>Remove question 32o-32p. “neurodevelopmental monitoring”</p> <p>Change questions from 32q-32r “Abdominal x-ray with bowel decontamination” and 32s-32t “Chelation therapy” to 35g-h “Chelation therapy/bowel decontamination”</p>	35a-p
33a-f	<p>Nutritional Assessment and Interventions: at what confirmed blood lead level do you initiate the following actions according to your jurisdiction’s case definition for lead in blood for children less than 6 years (72 months) of age?</p>	<p>Questions from this section are consolidated into the medical assessment section.</p> <p>Change questions from 33a-b. “diet evaluation” and 33e-f. “referral to nutritionist” to 35i-j “diet or nutrition evaluation”</p> <p>Change question from 33c-d</p>	35i-n

		“Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)” to 35m-n “Refer to Woman, Infants, and Children (WIC) program”	
34a-f	Developmental Assessment: at what confirmed blood lead level do you initiate the following actions according to your jurisdiction’s case definition for lead in blood for children less than 6 years (72 months) of age?	Questions from this section are consolidated into the medical assessment section. Remove question “34a-b. “conduct developmental assessment” Change questions from 34c-d. “refer for diagnostic evaluation for neurodevelopmental issues” and 34e-f. “refer for early intervention/stimulation programs” to 35k-l “Refer for diagnostic evaluation for neurodevelopmental issues or early intervention programs” Add question 35o-p “Refer to hospital for urgent lead poisoning evaluation and treatment”	35k-p
35	Are any of these actions implemented by all or some local health departments rather than at the state health department level?	Are any of these actions implemented by all or some local health departments rather than at the state/territorial/tribal health department level? Select all that apply	36
36	Are action(s) implemented by the local health department at a different blood lead level than levels set by the state health department?	Question removed	
		Add question “What barriers does your program face when practicing blood lead case management? (Select all that apply)”	37
37	Does your program receive Medicaid reimbursement for any of the following lead poisoning prevention related services?	Does your program receive Medicaid reimbursement for any of the following lead poisoning prevention related services? (Select all that apply)	38

A.16. Plans for Tabulation and Publication and Project Time Schedule

The data collection instrument will be sent to the state, tribal, local, and territorial lead poisoning prevention program project managers in Summer 2026 and annually through May 2029. An

initial invitation and follow-up email will also be sent (Attachments 6&7). Data collection will take approximately 4 weeks to complete. Data will be cleaned and analyzed by an LPPS Health Scientist using Excel and/or Power BI. Data will be aggregated by jurisdiction, shared with CDC-funded Childhood Lead Poisoning Prevention Programs (CLPPPs), and used in response to inquiries by the public, press, and Congress.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is appropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

References

Agency for Toxic Substances and Disease Registry (ATSDR). (2020). *Toxicological profile for lead*. U.S. Department of Health and Human Services.

Downes, J. R. (2022, March 7). *Lead hazards in U.S. housing: The American Healthy Homes Survey II*. HUD User. <https://archives.huduser.gov/portal/pdredge/pdr-edge-trending-030822.html>

Ruckart PZ, Jones RL, Courtney JG, et al. Update of the Blood Lead Reference Value — United States, 2021. (2021). *MMWR Morb Mortal Wkly Rep*,70:1509–1512. DOI: <http://dx.doi.org/10.15585/mmwr.mm7043a4>