Supporting Statement for Paperwork Reduction Act Submissions
Evaluation of the Community Choice Demonstration
(OMB # 2528-0337)

A. Justification

1. Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.

The Office of Policy Development and Research (PD&R), at the U.S. Department of Housing and Urban Development (HUD), is seeking approval to extend the information collection of individuals participating in the Community Choice Demonstration (formerly known as the Housing Choice Voucher Mobility Demonstration) ("Demonstration" for short). On May 31, 2022, and June 9, 2022, OMB approved the administration of a series of data collection instruments as part of the core Demonstration. On October 6, 2022, OMB approved non-substantive changes to this information collection; on December 18, 2023, OMB approved a revision to the collection to add three studies: the Home Assessment, the Child Assessment, and the Obesity and Diabetes Risk Assessment; on March 27, 2024, October 22, 2024, and May 28, 2025, OMB approved additional non-substantive changes to select instruments.

The Demonstration is a once-in-a-generation opportunity to build rigorous evidence on how to advance the long-held goals of expanding residential choice and facilitating moves to lower poverty areas by Housing Choice Voucher (HCV) families. Through this revised information collection request, HUD is seeking approval to continue the information collection using a subset of previously approved instruments with some revisions. More information about proposed revisions is provided under item 15 of this Supporting Statement. No new instruments are being added to this collection.

Demonstration Overview

The Consolidated Appropriations Act, 2019 (Pub. L. 116-6) and the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) authorized HUD to implement and evaluate the Demonstration. As described in the Federal Register Notice Docket Number FR-6191-N-01, HUD is implementing a multi-site randomized controlled trial (RCT) to test and evaluate the effectiveness of the Demonstration. The primary purposes of the Demonstration are to provide voucher assistance and mobility-related services to families with children to encourage such families to move to lower-poverty areas, to expand their access to opportunity areas, and to evaluate the effectiveness of the strategies pursued under the Demonstration. These neighborhoods which the Demonstration calls "opportunity areas" have been designated by the evaluation contractor, Abt Global, with input from HUD and the participating public housing agencies (PHAs) and were chosen based on several area indicators including family poverty rate, share of rental units occupied by HUD-assisted families with children, percentile on key

opportunity indices (Child Opportunity Index percentile and Opportunity Atlas), and test scores of nearby elementary schools.

Eight sites around the U.S. (which include 10 PHAs) joined the Demonstration[1] by offering mobility-related services to eligible families with children.[2] Both existing families with vouchers ("existing voucher families") and families newly offered a voucher from the waiting list ("waitlist families") are eligible to participate. Participating PHAs have adopted administrative policies that further enable housing mobility, increase landlord participation, and reduce barriers for families to move across PHA jurisdictions through portability.[3]

The Demonstration enrolled approximately 5,600 families over a four-year enrollment period (2022-2026)—of which approximately 5,000 are existing voucher families and approximately 600 are waitlist families.[4] The Demonstration randomly assigned families to either a treatment group or a control group. The treatment group was offered a comprehensive set of mobility-related services (CMRS) and the control group was offered standard PHA services offered through the HCV program. The study is evaluating whether CMRS helps families with children access and remain in opportunity areas and its cost-effectiveness. Impact is measured by whether families move to opportunity areas and whether they stay in those areas (up to two years after random assignment).

The Demonstration also includes two ancillary studies.[5] The first is the HUD-funded Child Assessment study that will assess the impact of CMRS on children's health and well-being. The second is the Johns Hopkins University (JHU)-led and National Institutes of Health[6]-funded Mobility Opportunity Vouchers for Eliminating Diabetes and Obesity (MOVED) study that will assess the impact of CMRS on adult obesity and diabetes risk. These two studies are being conducted together in four Demonstration sites and are expected to enroll 837 children ages 2 to 15 and 900 adults.

PD&R has contracted with Abt Global to lead the evaluation. Abt Global has subcontracted with JHU to collect the data for the Child Assessment study and JHU is also collecting the data for the Obesity and Type II Diabetes Risk Assessment.

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[1] The Demonstration includes the following eight metro areas: Cleveland, OH; Los Angeles, CA; Minneapolis, MN; Nashville, TN; New Orleans, LA; New York City, NY; Pittsburgh, PA; and Rochester, NY. Rochester and Nashville withdrew from the Demonstration in 2024 and 2025, respectively, but enrolled participants in those sites continue to be part of the evaluation.

[2] For the purpose of this Demonstration, eligible families are defined as households consisting of at least one adult and one child aged 17 or under.

[3] In the context of the Housing Choice Voucher program, portability refers to the process of moving from the jurisdiction of one PHA to the jurisdiction of another PHA. For more information, see https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/portability

[4] Originally, the Demonstration expected to enroll about 15,000 families. This target was reduced after two sites exited the demonstration and after HUD decided to cancel the design and implementation of a second treatment arm and shorten the implementation in early 2025.

[5] The Demonstration included a third ancillary study to examine the impacts of being offered CMRS on indoor air quality indicators and exposure to cockroach and mouse allergens. The Home Assessment study was cancelled in 2024 because of lower than expected enrollments, the withdrawal of one of the two sites implementing this study, and new research that questioned the study's ability to detect impact with the proposed methodology.

[6] The NIH funding is provided through the National Institute of Diabetes and Digestion and Kidney Diseases.

This Information Collection Request (ICR) seeks approval to extend the information collection using a subset of the previously approved instruments. No new instruments are being added to this collection.

Research Questions

Through the Demonstration, HUD will implement, test, and evaluate whether housing mobility programs expand access to opportunity areas. HUD has designed the Demonstration to answer a few confirmatory, secondary, and exploratory research questions. The ancillary studies have their own research questions.

Community Choice Demonstration

The confirmatory research questions motivating the Community Choice Demonstration are:

CCD-1. For voucher families with children, what is the effect of offering CMRS on moves to an opportunity area during the 12 months following random assignment? What is the effect for existing voucher families? What is the effect for waiting list families?

CCD-2. For voucher families with children, what is the effect of offering CMRS on the duration of residency in an opportunity area in the 24 months following random assignment?

The study includes secondary research questions, which are policy-relevant questions on which the study expects to be able to provide quantitative evidence and for which the study should have adequate statistical power to measure. The study's secondary research questions examine whether the impact results vary by site, for waiting list vs. existing voucher families, by household characteristics or by the characteristics of the families' origin neighborhood. The study also includes a secondary research question focused on understanding the costs of providing CMRS.

The study includes exploratory research questions, which are policy-relevant questions for which the study is expected to provide useful evidence but not necessarily a definitive answer. This could be because the answers will rely on qualitative evidence that does not lend itself to definitive conclusions or because the study may be underpowered to detect some policy-relevant impacts. The study's exploratory research questions focus on understanding which services within the CMRS appear most effective in facilitating moves to opportunity areas and the successes and challenges of program implementation.

Child Assessment

The research questions motivating the Child Assessment are:

CA-1. How does the offer of CMRS affect the following domains two years after random assignment? (a) parenting; (b) child executive function; (c) child behavior; (d) child anxiety; (e) child diet and physical activity; and (f) other aspects of child well-being.

CA-2. Does the impact of being offered CMRS on these domains vary by child age or sex?

The Obesity and Type II Diabetes Risk Assessment

The research questions motivating the Obesity and Type II Diabetes Risk Assessment are:

OD-1. How does the offer of CMRS affect obesity and type II diabetes risk two years after random assignment compared to the control group among adults and children?

OD-2 What behavioral, psychosocial, structural, and other factors link neighborhoods to obesity and type II diabetes risk?

OD-3. Does the impact of being offered CMRS vary by sociodemographic and other characteristics?

Data Collection

To answer the research questions, data will be collected through a variety of methods including direct measurements, interviews, observations, surveys, and the collection of administrative records. Each assessment's procedures are outlined below. Participants will be asked to provide informed consent before any data collection takes place. Participation in the Community Choice Demonstration, Child Assessment, and Obesity and Type II Diabetes Risk Assessment is voluntary. Households participating in the main Demonstration are not required to participate in any of the additional data collections.

Community Choice Demonstration

One data collection instrument in the main Demonstration will continue to be administered after the expiration of the previously approved data collection[7]:

- **Mobility Service Tracking Tool**. Information about the provision of comprehensive-mobility related services (CMRS) offered to households in the treatment group and collected via a web-based mobility services delivery tracking tool. See attachment A.

Child Assessment

In the Child Assessment, the evaluation team (Abt Global until 2025 and its subcontractor JHU starting in 2026) is administering validated child and parent/guardian assessments at baseline at four of the eight Demonstration sites until mid-2026. In the Fall of 2026, the evaluation team will start administering validated child and caregiver two-year follow-up assessments. Data is collected from one randomly selected child and the child's parent or guardian in an estimated 837 families with an eligible child between the ages of 2 and 15 at baseline. These families are split between families in the group offered CMRS and the control group. All of these families also participate in the Obesity and Type II Diabetes Risk Assessment, described in more detail

[7] The Demonstration ended enrollment in the study on June 30, 2026. The study also completed all qualitative and cost study interviews. The following previously approved instruments will be discontinued after December 31, 2026: (1) Household Roster and Baseline Information Form; (2) Baseline Survey; (3) PHA Staff Interview Guide; (4) Mobility Service Providers Interview Guide; (5) Interview Guide for Participating Families Currently Searching for Housing; (6) Interview Guide for Participating Families Who Have Leased Up; (7) Interview Guide for Opportunity Area Landlords; and (8) Cost Data Collection Interview Guide.

below. The following data collection instruments will continue to be administered after the expiration of the previously approved data collection[8]:

- **Survey About Child – Follow-up (questions asked of parent or guardian).** The parent or guardian will report on child behavioral and mental health, physical health, social functioning, and education as well as on the caregiving practices of the parent or guardian and the housing environment using validated assessments on the two-year follow-up instrument. See Attachment C.
- **Direct Child Assessment and Survey – Follow-up**. A trained interviewer will administer a two-year follow-up brief touch-screen-based assessment of children's executive functioning for all children. The interviewer will also administer a brief survey to school-aged children. See Attachments D.1 and D.2.

The Obesity and Type II Diabetes Risk Assessment

In the Obesity and Type II Diabetes Risk Assessment, In the Child Assessment, the evaluation team (Abt Global until 2025 and its subcontractor JHU starting in 2026) is administering baseline data collection at four of the eight Demonstration sites until mid-2026 (the same sites as the Child Assessment). In the Fall of 2026, JHU will start administering two-year follow-up data collection. The data will be collected for 900 families in the group offered CMRS and in the control group from one parent or guardian and one child. (An estimated 837 of these families, who have an eligible child aged between 2 and 15, will also be participating in the Child Assessment, as described above.) Households that participate in the Obesity and Type II Diabetes Risk Assessment, but not the Child Assessment are those that do not have a child that meets the age eligibility.

The following data collection instruments will continue to be administered after the expiration of the previously approved data collection.[9] Participants will have the option of participating in some or all of these data collection activities:

- **Adult Survey – Follow-up.** The adult will respond to a 60-minute interviewer-administered two-year follow-up survey about behavioral, psychosocial, perceived contextual, and structural factors, that are potentially associated with obesity and type II diabetes risk. See Attachment H.
- **Anthropometric Assessment (adult).** The adults will have their height, weight, and waist circumference measured by trained research staff. All measures will be taken three times and averaged. See Attachment I.
- **Anthropometric Assessment (child).** The child will have their height, weight, and waist circumference measured by trained research staff. All measures will be taken three times and averaged. See Attachment J.

[8] Since the Demonstration ended enrollment in the study on June 30, 2026, the baseline data collection for the Child Assessment will be completed in 2026. The following previously approved instruments will be discontinued after December 31, 2026: (1) Survey about Child – Baseline; and (2) Direct Child Assessment and Survey – Baseline.
[9] Since the Demonstration ended enrollment in the study on June 30, 2026, the baseline data collection for the Obesity and Type II Diabetes Risk Assessment will be completed by the end of 2026. This previously approved instrument will not be needed after December 31, 2026: Adult Survey – Baseline.

- **Blood Spot Samples (adult).** To assess diabetes risk, research staff will collect a blood spot sample from the adult respondent to measure hemoglobin A1c. Each blood spot sample requires only four drops of blood from the fingertip. Participants will be provided with their results and resources should they need or want to follow-up with their healthcare provider. See attachment K.
- **Home Observations/Housing Assessment**. Interviewer observations will focus on home and neighborhood observations that are risk factors for poor health, including factors that impact diet and exercise. The interviewer will record observations about the unit using a brief checklist presented in attachment L.
- **Accelerometers (adult).** A subset of 400 (about half from the group offered CMRS and half from the control group) of the adults will wear an accelerometer, a device-based motion sensor that captures an individual's movement as an objective, continuous measurement of physical activity and sleep, for 7 consecutive days. See Attachment M.
- **Accelerometers (child).** A subset of 400 (about half from the group offered CMRS group and half from the control group) children will wear an accelerometer for 7 consecutive days. See Attachment N.
- **Blood Pressure Readings (adult).** Trained research staff will take blood pressure assessments on a subset of 900 adults to obtain a direct measure of blood pressure which is strongly associated with obesity and diabetes risk and hypothesized to be related to neighborhood change**.** See Attachment O.
- **Semi-Structured Interviews (adult).** Only at follow-up, a subset of 100 adults, 25 from each site (oversampling the treatment group relative to the control group 2:1) will complete a 90-minute semi-structured in-depth interview. The interviews will dive deeper into the factors explored in the survey that are potentially associated with obesity and type II diabetes risk, such as perceived barriers and facilitators to eating a healthy diet, the role of mental health and social support, and exposure to violence. See Attachment Q.
- **Tracking Contacts:** JHU will contact families to update their contact information on a quarterly basis beginning in the sixth month after JHU recruitment. JHU will contact each adult who completed a baseline interview to confirm or update their name, address, phone, and email. The individual will also be asked to provide the name, address and phone number of someone who will always know how to reach them. Contacts with these individuals will alternate between phone for one contact and email/text for the next contact.
    - **Tracking Emails/Texts.** JHU will attempt to contact the adult by email or text at two points—9 and 15 months after JHU recruitment. These updates are expected to take 8 minutes on average to complete. See Attachment R.
    - **Tracking Calls.** JHU will attempt to contact the adult by phone at three points—6, 12, and 18 months after random assignment. These calls will take 10 minutes on average to complete. See Attachment S.

Each assessment leverages the baseline's study randomized experimental framework. Abt Global will conduct balance testing to ensure that characteristics of participants in the treatment and control groups at baseline are statistically equivalent and will apply weights if they are

unbalanced so that the analyses yield robust impact estimates. Notably, the study design does allow for isolating the impact of the intervention on child health across a range of individual characteristics because the impact of moving to an opportunity area will be measured for each study participant at the individual level and compared against their baseline health measures.

Instruments and Attachments

Below is a list of all attachments, including data collection instruments. All attachments that are data collection instruments are marked with an asterisk.

- Mobility Services Tracking Tool (Attachment A)

1. The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Consent* (Attachment B)
    - The Child Assessment: Survey about Child – Follow-up (questions asked of parent or guardian)* (Attachment C)
    - The Child Assessment: Direct Child Assessment – Follow-up* (Attachment D.1)
    - The Child Assessment: Direct Child Assessment Executive Functioning Follow-up* (Attachment D.2)
    - The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Flyer (Attachment E.1)
    - The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Advance Letter (Attachment E.2)
    - The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Email Reminder (Attachment F.1)
    - The Child Assessment & The Obesity and Type II Diabetes Risk Assessment – Follow-up Phone Call Script (Attachment F.2)
2. The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Consent* (Attachment G)
    - The Obesity and Type II Diabetes Risk Assessment: Adult Survey – Follow-up* (Attachment H)
    - The Obesity and Type II Diabetes Risk Assessment: Anthropometric Assessments – Follow-up * (adult) (Attachment I)
    - The Obesity and Type II Diabetes Risk Assessment: Anthropometric Assessments – Follow-up * (child) (Attachment J)
    - The Obesity and Type II Diabetes Risk Assessment: Blood Spot Samples – Follow-up (adult)* (Attachment K)
    - The Obesity and Type II Diabetes Risk Assessment: Home Observations/Housing Assessment – Follow-up * (Attachment L)
    - The Obesity and Type II Diabetes Risk Assessment: Accelerometers – Follow-up (adult)* (Attachment M)
    - The Obesity and Type II Diabetes Risk Assessment: Accelerometers – Follow-up (child)* (Attachment N)
    - The Obesity and Type II Diabetes Risk Assessment: Blood Pressure Readings – Follow-up (adult)* (Attachment O)
    - The Obesity and Type II Diabetes Risk Assessment: Semi-Structured Interviews: Consent* (Attachment P)

- The Obesity and Type II Diabetes Risk Assessment: Semi-Structured Interviews (adult)* (Attachment Q)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Tracking Emails/Texts (Attachment R)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Tracking Calls (Attachment S)
- Changes to Previously Approved Instruments and Justification (Attachment T)

2. Indicate how, by whom and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.

Purpose

This is an extension of an approved information collection. The information collected in support of the Demonstration will allow HUD, the evaluation team (Abt Global and JHU), PHAs, other researchers, and policymakers to understand the effects of various mobility-related services on a household's ability to make and sustain a move to an opportunity area. A primary goal of the Demonstration is to better understand the extent to which mobility-related services succeed in facilitating moves to opportunity areas, and whether and to what extent families who move to opportunity areas stay in those areas. The Demonstration also seeks to better understand the individual, PHA, and local community factors that either support or hinder the effectiveness of mobility-related services. Another aim of the Demonstration is to gain insight into the costs of each component of the mobility-related services provided and which services are most cost-effective.

A long-term goal of the Demonstration is to measure whether there are differences in long-term outcomes for those who make and sustain moves to opportunity areas and those who do not. Of particular importance is the ability to measure whether children in households that move to opportunity areas do better in school and earn a higher income later in life. The study design allows for ongoing collection of administrative data from several government agencies to help measure differences in long-term outcomes.

The purpose of the additional assessments is to see whether moving to opportunity areas positively impacts health outcomes. These new assessments will add important information on the impacts of the Demonstration. This information cannot be collected in other ways. The Child Assessment will assess how being offered CMRS may affect children's conduct problems and physical and mental health. The Obesity and Type II Diabetes Risk Assessment will assess how being offered CMRS affects the risk of obesity and type II diabetes (primarily for the head of household and secondarily for one child in each household). Each of these assessments will leverage the CCD's existing randomized experimental design framework to assess the impact of the overall CCD outcome (moving to opportunity areas) on child health, while adjusting for individual characteristics that may affect outcomes, including unobservable characteristics.

The purpose of each data collection activity is described in greater detail below.

Mobility Services Tracking Tool

The collection of data on the mobility-related services provided to treatment group households will provide a key input for the evaluation. These data will be collected primarily through a mobility services delivery tracking tool developed by the evaluation contractor and will serve as a user-friendly case management system and mobility program management information system (MIS) for staff, either at PHAs or at partner organizations, that are providing mobility-services. The mobility services tracking tool will be available to all participating organizations to help ensure collection of a uniform set of data elements (contacts between staff and households, between staff and landlords, costs of services provided, etc.) and to minimize coordination efforts and PHA burden.

Child Assessment

Moving to an opportunity area can offer children opportunities that significantly improve their well-being. In their analysis of long-term outcomes for children in the Moving to Opportunity Demonstration, for example, Chetty et al.[10] find improvements in earnings and educational outcomes of young adults who moved to a low-poverty area before age 13. Less is known about the short-term impacts of moving to a lower-poverty neighborhood on children and their parents or guardians. The focus of the Child Assessment is to understand how being offered CMRS might affect children's well-being in the short term, focusing on outcomes in mental and physical health and behavior and conduct. In doing so, it will collect data to examine both *outcomes* of CMRS – for instance, the effects of CMRS on subsequent child physical health – as well as *mediators* – that is, factors that either facilitate (mediate) or suppress (moderate) any main effect of CMRS. As an example, this analysis will examine parenting practices as a mediator of the relationship between CMRS and subsequent effects on child mental and behavioral health. Parenting practices are hypothesized to mediate the relationship between community disadvantage and child behavioral health. The family stress model[11] theorizes that parental distress can contribute to child behavior problems through disrupted parenting practices. An application of this model to community-based stressors (e.g., concentrated disadvantage and violent crime) finds that these stressors are associated with children's behavior through similar processes of parental distress and parenting.[12] To the extent that improved safety in children's environments reduces parental stress, this model hypothesizes that children would display fewer behavioral problems through increased use of positive parenting practices.

The Obesity and Type II Diabetes Risk Assessment

Prior research on long-term outcomes of the Moving to Opportunity Demonstration found that being offered the chance to move to a low-poverty neighborhood reduces adult obesity and type

[10] Chetty, R., Hendren, N., & Katz, L. F. (2016). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity experiment. *American Economic Review*, *106*(4), 855–902. https://doi.org/10.1257/aer.20150572

[11] Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*, *13*, 85-90. https://doi.org/10.1016/j.copsyc.2016.05.008

[12] Votruba-Drzal, E., Miller, P., Betancur, L., Spielvogel, B., Kruzik, C., & Coley, R. L. (2021). Family and community resource and stress processes related to income disparities in school-aged children's development. *Journal of Educational Psychology*, *113*(7), 1405. https://doi.org/10.1037/edu0000589

II diabetes risk. Less is known about the short-term impacts of moving to a lower-poverty neighborhood on obesity and type II diabetes risk and little is known about the many potential pathways. These pathways are likely varied, potentially impacting dietary intake and physical activity through a range of different mechanisms, including but not limited to changes in stress, different access to food, transportation, and exercise venues, and family routines. These further intersect with the healthcare system and with other aspects of health, such as blood pressure. The focus of the Obesity and Type II Diabetes Risk Assessment is to investigate to what extent being offered CMRS impacts obesity and type II diabetes risk among adults and obesity among children, relative to the control group and use a range of methods to identify potential pathways and spillover effects.

Who Will Use this Information?

PHAs and service providers will use the Mobility Services Tracking Tool to manage and track service delivery to treatment families.

The evaluation contractor will use the information collected through the Mobility Services Tracking Tool and the Child Assessments to prepare reports to HUD on the findings of the Demonstration. The primary beneficiary of these reports (and the data used to inform the reports) will be HUD. HUD will use the information from the study to understand the impact of mobility-related services on short-term impacts on adults and children who move to an opportunity area on health, mental health, and other outcomes. The findings of the impact analyses for Community Choice Demonstration and the Child Assessment will be published by HUD.

Researchers at JHU will analyze the information collected through the Obesity and Type II Diabetes Risk Assessment as part of the MOVED study and report on the results in one or more peer-reviewed journals; they will use this information to determine the extent to which moving to an opportunity area affects adult and child health.

Findings from the Demonstration and two assessments are relevant to a broad set of policymakers, voucher families, and researchers. Data from the Demonstration and two assessments will also be made available to other interested researchers who agree to required privacy and data security safeguards.

Instrument Item-by-Item Justification Chart

Exhibit A.1 lists key information about each instrument and the corresponding attachment on which it appears, as well as its content, and reason or purpose. All respondents are participants who are a part of the Demonstration.

Exhibit A.1: Item-by-Item Justification Chart

Instrument	Content	Reason/Purpose
Mobility Services Tracking Tool		

Mobility Services Tracking Tool (Attachment A)	User-friendly case management system and mobility program management information system (MIS) for staff, either at PHAs or at partner organizations, that are providing mobility-services.	To ensure collection of a uniform set of data elements (contacts between staff and households, between staff and landlords, costs of services provided, etc.) and to minimize coordination efforts and PHA burden.
Child Assessment		
Child Assessment & Obesity and Type II Diabetes Risk Assessment: Consent (Attachment B)	Form outlining what information will be collected in the Obesity and Type II Diabetes Risk Assessment & Child Assessment, how the information will be used, and next steps.	To obtain assent from children ages 10+. The form to obtain full consent for The Obesity and Type II Diabetes Risk Assessment & Child Assessment from parents can be found in Attachment L.
Survey about Child – Follow-up (questions asked of parent or guardian) (Attachment C)	Interviewer-administered two-year follow-up surveys with parent or guardian reporting on child behavioral and mental health, physical health, number of schools attended, school absences, school engagement, and community activities outcomes for one child ages 2-15 at baseline and on their caregiving practices, housing quality, and home environment.	Obtain information from the parent or guardian about potential effects of intervention on child and caregiving outcomes and on the home environment as a potential moderator of intervention effects.
Direct Child Assessment – Follow-up (Attachment D.1 and D.2)	Includes a two-year follow-up self-completed touch screen -based assessment of child executive functioning of a single randomly selected child in each study household and a brief interviewer-administered survey for those children who are 8 or older on child behavioral and mental health and physical health outcomes.	Assess intervention effects on children's executive functioning and mental and physical health.
The Obesity and Type II Diabetes Risk Assessment		
Obesity and Type II Diabetes Risk Assessment & Child Assessment Consent (Attachment G)	Form outlining what information will be collected in the adult survey, adult anthropometric assessments, blood spot sample, accelerometer, child anthropometric assessment, blood pressure monitoring and child accelerometer. The form will also detail how the information will be	To obtain informed consent from adults to participate in the research study, and for the child of whom they are the parent or guardian to participate. (please see Attachment G for assent). Children ages 10+ will also provide their written assent in the associated Attachment C.

	used, and next steps.	
Adult Survey – Follow-up (Attachment H)	Interviewer-administered two-year follow-up 70-minute survey that includes domains related to diet and exercise, sleep habits, mental health, perceived neighborhood and food environment, social support, discrimination, healthcare access, and use of social services.	To understand how moving to an opportunity neighborhood has the potential to impact adult health outcomes, like obesity and type II diabetes, and the pathways through which these changes are likely to occur. By administering this survey at both baseline (before moving) and follow-up (after moving) to a group being offered CMRS and a control group, researchers will be able to determine whether these factors change between study groups over the 2-year period.
Anthropometric assessments (adult) – Follow-up (Attachment I)	At each home visit, trained research staff will measure height and weight of the adult using a portable stadiometer and digital scale along with waist circumference. Body mass index (BMI) (weight in kg divided by height in m^2) will be calculated.	To assess whether adults in families offered CMRS (intervention group) exhibit changes in obesity risk after 2 years compared to the control group that receives no special mobility services. Height and weight will be used to calculate BMI,[13] one of the primary outcome measures for adults in this research study, and waist circumference will be used to assess abdominal obesity.
Anthropometric assessments (child) – Follow-up (Attachment J)	At each home visit, trained research staff will measure height and weight of the enrolled child aged 2-15 using a portable stadiometer and digital scale along with waist circumference. Age- and sex-standardized BMI z-scores for children will be calculated.	To assess whether children in families offered CMRS exhibit changes in obesity risk after 2 years compared to the control group that receives no special mobility services. Height and weight will be used to calculate BMI z-score, the primary outcome measure for children in this research study and waist circumference will be used to measure abdominal obesity.
Blood spot samples (adult) – Follow-up (Attachment K)	At each home visit, trained research staff will collect capillary blood from adults to measure HbA1c using a mail-in testing kit for the adult.	To assess whether adults in families offered CMRS (intervention group) exhibit changes in type II diabetes risk (HbA1c levels) after 2 years compared to the control group that receives no special mobility services.
Home Observations/Housing Assessment – Follow-	Pre- and post-intervention checklist and questionnaire to be completed by field staff.	Report on observations within units and neighborhood that complement self-reported survey information.

[13] This study is using BMI to monitor average changes in body weight independent of height in a population over time. BMI is a valid measure for this purpose across racial/ethnic groups (that is, weight scales similarly with height in Non-Hispanic white, Non-Hispanic Black, and Mexican men and women when controlling for adiposity and age). However, this study is not communicating health risks with individual participants based on BMI. This is because it can be problematic when BMI is used out of context to communicate health risks with individuals due to differences in the relationship between fat mass and BMI across racial/ethnic groups.

up (Attachment L)		
Accelerometers (adult) – Follow-up (Attachment M)	At the baseline home visit, a random subset of adult participants from each study group (approximately half from the group offered CMRS and the other half from the control group) will be offered the opportunity to wear the accelerometer at baseline and at 2-year follow-up. At the two time points, the accelerometer will be fastened to the participant's non-dominant wrist with an adjustable band to be worn for 7 consecutive days.	To understand how physical activity and sleep may change for adults between groups when moving to an opportunity area.
Accelerometers (child) – Follow-up (Attachment N)	At the baseline home visit, a random subset of child participants aged 2-15 from each study group (approximately half from the group offered CMRS and the other half from the control group) will be offered the opportunity to wear the accelerometer at baseline and 2-year follow-up. At the two time points, the accelerometer will be fastened to the participant's non-dominant wrist with an adjustable band to be worn for 7 consecutive days.	To understand how physical activity and sleep may change for children between groups when moving to an opportunity area.
Blood pressure reading (adults) – Follow-up (Attachment O)	Blood pressure will be measured using an electronic blood pressure monitor at baseline and 2-year follow-up.	Obtain direct measure of blood pressure which is strongly associated with obesity and type II diabetes risk and hypothesized to be related to neighborhood change.
Consent for semi-structured interviews (Attachment P)	Form outlining what information will be collected in the in-depth interview, how the information will be used, and next steps.	To obtain informed consent from adults to participate in the 90-minute in-depth interview.
Semi-structured interviews (Attachment Q)	Interviewer administered 90-minute semi-structured in-depth interview with a subset of adults from each study group (group offered CMRS and control group). Interview questions will dive deeper into concepts explored in the initial questionnaire, such as the perceived barriers and facilitators to eating healthful foods, the role of mental health and social support in influencing behavioral factors.	To elicit perceived mechanisms through which randomization to CRMS relative to the control group impacts health and well-being.
Tracking Email/Text	Online portal with unique login	To obtain updated contact information in

(Attachment R)	where the adult can update or confirm their name, address, phone, and email information as well as contact information for someone who will always know how to reach them. Self-administration expected to take 8 minutes.	order to maximize the response rates for the follow-up data collection efforts
Tracking Call (Attachment S)	Interviewer administered 10-minute call where interviewers will ask the adult to update or confirm their name, address, phone, and email information as well as contact information for someone who will always know how to reach them.	To obtain updated contact information in order to maximize the response rates for the follow-up data collection efforts

Agency Use of the Information Received from the Current Collection

HUD completed and published the first report detailing the early implementation of the Demonstration. The Rapid Cycle Evaluation, published in early 2025, provided preliminary findings on the outcomes for 596 families with children who enrolled in the first 8 months of the 5-year Demonstration through March 2023. An analysis of 12 months of data indicates that the Demonstration is having a statistically significant, positive impact on moves to opportunity areas. The evaluation found that 23.7 percent of families with children who received CMRS moved to an opportunity area, compared to 4.1 percent of families in the control group, a 19.6 percentage point impact. Abt Global is completing a new report assessing the 3-year impact of CMRS on moves to opportunity areas that is expected to be published by the end of 2026.

3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.

The evaluation team uses automated technology in several ways as a means to enhance the collection of information under the Demonstration and reduce burden.

The enrollment and service delivery tracking tool is a web-based data collection system that PHA staff use to collect baseline information on approximately 5,600 households who enrolled in the demonstration until June 2026 and to track mobility service delivery until January 2027.

In the Child Assessment and the Obesity and Type II Diabetes Risk Assessment, the evaluation team (Abt Global and JHU) uses automated technology to enhance the collection of information under the Demonstration and reduce burden.

- They program instruments using Qualtrics, the evaluator's data collection platform, and interviewers administer the surveys in person using their computers. The instruments

allow the evaluator to include automatic skip patterns that route participants to only questions that are relevant to them based on their previous answers. The evaluator also includes programmed data validations to prevent outliers and inconsistent answers as well as scripted probes for interviewers so that they can follow up on inconsistent or unclear responses.

- The evaluator also uses touch screen devices for self-administered portions of the data collection. For example, they administer the touch screen-based Minnesota Executive Functioning Scale assessment to children to streamline data collection.
- The evaluation team implements a multi-pronged and technologically enhanced strategy to track and retain enrolled participants across the study period and to field the data collection. To encourage participant tracking and engagement, the team established a project website. The website serves as an electronic "home" for the study. Participants are able to go to a stable URL at any time to log on and update their contact information. The website also includes updates on study activities and a set of Frequently Asked Questions (FAQs), both of which help keep participants engaged with the study. Between enrollment and follow-up, the evaluation team also reaches out to participants to remain engaged in the study using phone calls, SMS texts, and emails, so that they can strengthen their rapport with participants and update their contact information. This helps ensure that interviewers can easily reach participants in their preferred and most convenient communication mode for follow-up data collection.
- Consistent with enrollment into the main study, the evaluation team obtains informed consent electronically, subject to state and local laws and Institutional Review Board (IRB) requirements. Having electronic consent reduces the paperwork requirements of the study, reduces the staff labor necessary to track the receipt status of paper consent forms and streamlines the informed consent process with participants.

4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2.

Wherever possible, the evaluation team draws upon HUD and PHA administrative data to reduce the burden of direct data collection from the study participants and to avoid duplication of effort by collecting data available elsewhere. For example, social security number of the head of household is necessary at the time of enrollment to ensure proper matching to HUD and PHA administrative data and ensure that the head of household was not previously enrolled in the study. However, social security numbers will not be obtained for other household members at enrollment, as the evaluation team can obtain that data from HUD and PHA administrative data.

5. If the collection of information impacts small businesses or other small entities describe any methods used to minimize burden.

There are no small business respondents or other small entities in this phase of the data collection.

6. Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.

The Consolidated Appropriations Act, 2019 (Pub. L. 116-6) and the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) authorized and required the U.S. Department of Housing and Urban Development (HUD) to implement and evaluate the Housing Choice Voucher (HCV) Mobility Demonstration (now known as the Community Choice Demonstration.

If the data included in this information collection request is not collected, HUD would be unable to conduct the research necessary to meet the statutory requirements for an evaluation of the Demonstration. Specifically, HUD would be unable to adequately determine:

- whether or not households can sustain moves to opportunity areas,
- what, if any, of the services received enabled them to do so, and
- what the long-term outcomes are for both adults and children in households who do make opportunity moves relative to those who do not.

The burden has been reduced to the minimum necessary to achieve the purposes of the Demonstration and the two ancillary studies. A two-year follow-up wave is the minimum needed to measure treatment impact per the research design. No technical or legal obstacles to reducing burden have been identified beyond the need to protect privacy and ensure that interviewees engage in informed consent.

7. Explain any special circumstances that would cause an information collection to be conducted in a manner:

- requiring respondents to report information to the agency more than quarterly;
    - Not applicable.
- requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
    - Not applicable.
- requiring respondents to submit more than an original and two copies of any document;
    - Not applicable.

- requiring respondents to retain records other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
    - Not applicable.
- in connection with a statistical survey, that is not designed to produce valid and reliable results than can be generalized to the universe of study;
    - Not applicable.
- requiring the use of a statistical data classification that has not been reviewed and approved by OMB;
    - Not applicable.
- that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
    - Not applicable.
- requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.
    - Not applicable.

The proposed data collection activities are consistent with the guidelines set forth in 5 CFR 1320 (Controlling Paperwork Burdens on the Public). There are no special circumstances that require deviation from these guidelines. Thus, each of the requirements above are **"Not Applicable"** to this collection.

8. If applicable, provide a copy and identify the date and page number of publications in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.

- **Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping disclosure, or reporting format (if any) and the data elements to be recorded, disclosed, or reported.**
- **Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be**

circumstances that preclude consultation in a specific situation. These circumstances should be explained.

The notice, soliciting comments on the information collection, was posted in the Federal Register on 05/08/2026, Volume 91, Number 89, pages 25370-25371, and provided a 60-day period for public comment. During the notice and comment period, no public comments were received. Please see the link to the Federal Register notice below.

2026-09138.pdf (govinfo.gov)

For a list of those consulted on this study outside of HUD, please see Supporting Statement B, Section 5.

9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.

Each of the assessments and/or their components have incentives that are provided to acknowledge the significant time that respondents spend participating. Exhibit A.3 shows the planned incentive amount for each respondent type. Baseline data collection and associated incentives will be completed under the currently approved data collection by the expiration date of December 31, 2026. Only incentives for the follow-up data collection that will apply after approval of this data collection request have been included in the exhibit.

Exhibit A.3: Planned Respondent Incentives

Information Collection	Incentive Amount	Incentive Type
Child Assessment – Follow-up	$35	Gift Card
Obesity and Type II Diabetes Risk Assessment survey – Follow-up (adult)	$70	Gift Card
Obesity and Type II Diabetes Risk Assessment Anthropometric Assessment – Follow-up (adult)	$20	Gift Card
Obesity and Type II Diabetes Risk Assessment Anthropometric Assessment – Follow-up (child)	$20	Gift Card
Obesity and Type II Diabetes Risk Assessment Blood spot samples – Follow-up	$25	Gift Card
Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment – Follow-up (adult)	$35	Gift Card
Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment –	$35	Gift Card

Follow-up (child)		
The Obesity and Type II Diabetes Risk Assessment: Blood pressure readings – Follow-up	$15	Gift Card
Semi-structured interviews for subset of Obesity and Type II Diabetes Risk Assessment	$100	Gift Card

A major justification for the use of incentives is the length of each assessment. Assessments that take about 60 minutes or more to complete could interfere in family commitments or result in unforeseen other expenses associated with research participation. Without offsetting the direct costs incurred by respondents for attending (which may include time off from paid work), the evaluation team increases the risk that only those individuals able to overcome the financial barriers to attend will participate in the study, thus limiting the experiences the evaluation is able to capture. Further, leading survey research organizations, American Association for Public Opinion Research (AAPOR) and American Statistical Association (ASA), agree that incentives improve response rates and are financially prudent for researchers, because they reduce time spent pursuing responses and improve the ability to interview families of interest.[14]

To avoid coercion, the consent statements for each interview guide accurately states known benefits and risks of participation without exaggerating them. Individuals with disabilities are provided reasonable accommodations, and the evaluation team ensures effective communication with individuals with disabilities during this study. Similarly, meaningful access is provided to speakers with limited English proficiency.

10. Describe any assurance of confidentiality provided to respondents and the basis for assurance in statute, regulation, or agency policy.

Because of the nature of the information collected from and about study participants, strict confidentiality procedures are followed for this evaluation. The information requested under this collection is protected and held confidential in accordance with 5 U.S.C. § 552a (Privacy Act of 1974) and OMB Circular No. A-130. Federal disability law provides further protection to ensure the confidentiality of information that respondents disclose about any disability. Study participants are assured they need not disclose any medical or disability related information if they do not wish to, but if they do disclose that information it will not be shared in a personally identifiable way with anyone other than study team and HUD's Office of Policy Development & Research or used in any way to impact their eligibility for any public program or activity.

[14] Berlin, Martha, Leyla Mohadjer, Joseph Waksberg, Andrew Kolstad, Irwin Kirsch, D. Rock, & Kentaro Yamamoto. 1992. "An experiment in monetary incentives." Proceedings of the Survey Research Methods Section of the American Statistical Association. Alexandria, VA: American Statistical Association.

As required by 5 U.S.C. 552a (Privacy Act of 1974), HUD published a Systems of Record Notice (SORN) identified as Housing Choice Voucher (HCV) Mobility Demonstration Evaluation Data Files and modified to Community Choice Demonstration Evaluation Data Files, and bearing the system number PD&R/RRE 09, in the Federal Register. The main study was published on May 27, 2022, Volume 87, Number 103, pages 32179-32181, and it was effective as of June 27, 2022. HUD modified the SORN after the inclusion of the Child Assessment and Obesity and Type II Diabetes Risk Assessment. The modified SORN was published in the Federal Register on January 23, 2024, Volume 89, Number 15, pages 4326-4329, and the routine uses became effective as of February 23, 2024. Please see link to the notices below.

https://www.federalregister.gov/documents/2022/05/27/2022-11452/privacy-act-of-1974-system-of-records

https://www.federalregister.gov/documents/2024/01/23/2024-01217/privacy-act-of-1974-system-of-records

Prior to beginning the data collections included in this submission, the study protocols and materials were reviewed in detail by Abt Global' IRB and Abt Global' Cybersecurity team. After JHU assumed responsibility for the Child Assessment and Obesity and Type II Diabetes Risk Assessment data collection in 2026, JHU's IRB became the IRB of record for these two studies. JHU's IRB reviewed in detail the study protocols and materials included in this package.

Informed Consent

The study has been designed to allow all potential participants to make a genuinely informed decision about participation. Vigorous outreach with a clear message and strong supporting materials have been used to ensure that families enrolled in the study understand the entirety of each assessment if applicable.

The consent forms for the Child Assessment and the Obesity and Type II Diabetes Risk Assessment were combined into a single consent form; respondents have the ability to decide which elements of the study they wish to participate in and have the child participate in. The consent form is written in plain language so that participants can understand it. Options for those who need reasonable accommodations for individuals with disabilities are provided for families interested in participating. Language assistance options are provided for persons with limited English proficiency to be able to enroll in the study and provide informed consent.

As with all the Child Assessment, participants in the Obesity and Type II Diabetes Risk Assessment have the option of participating in some or all of the data collection activities.

Data Confidentiality Protections

The evaluation team protects respondent privacy to the extent permitted by law and complies with all Federal and Departmental regulations for private information. The evaluation team developed a Data Security Plan that assesses all protections of respondents' Personally Identifiable Information (PII). The evaluation team ensures that all employees, subcontractors (at

all tiers), and employees of each subcontractor, who perform work under this contract/subcontract, are trained on data privacy issues and comply with the above requirements.

The evaluation team uses Federal Information Processing Standard compliant encryption (Security Requirements for Cryptographic Module, as amended) to protect all instances of sensitive information during storage and transmission. The evaluation team securely generates and manages encryption keys to prevent unauthorized decryption of information, in accordance with the Federal Processing Standard. The evaluation team: ensures that this standard is incorporated into the evaluation's property management/control system; establishes a procedure to account for all laptop computers, desktop computers, and other mobile devices and portable media that store or process sensitive information. Any data stored electronically is secured in accordance with the most current National Institute of Standards and Technology (NIST) requirements and other applicable Federal and Departmental regulations. In addition, the evaluation team submitted a plan for minimizing to the extent possible the inclusion of sensitive information on paper records and for the protection of any paper records, field notes, or other documents that contain sensitive or PII that ensures secure storage and limits on access.

All data collected and maintained by the evaluation team is stored securely in the cloud-based system. Data extracted from those tools and all other data collected for this study resides within the secure ACE 3 Data Collection Platform maintained by evaluation contractor Abt Global. Only staff with a need to use the data have access to the data. Data from JHU is stored on the SAFE-STOR, a secure, cloud-based research platform managed by Johns Hopkins Research IT.

An assurance of confidentiality to the extent provided by law is included in the study consent agreement through which participants provide informed consent. An assurance of confidentiality to the extent provided by law will also be made to all respondents as part of the introduction to each of the data collection activities.

11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

The instruments included in this information collection request contain some questions that may be deemed sensitive in nature by some study participants, such as weight control behaviors and perceptions of body image, physical health, mental health, police involvement, substance use, experiences of discrimination and bullying, food security status, and participation in social services programs. This information is important to the study to understand potential pathways through which moving to an opportunity neighborhood may affect health and mental health outcomes, such as obesity and type II diabetes risk.

All respondents will be informed that their participation is voluntary, that they can choose not to answer any question, and that their responses will be kept confidential to the fullest extent

possible under the law. The limited circumstances that would require a breach of confidentiality are outlined by the IRB and pertain to such matters as abuse. Prior to any questions being asked, the interviewer will obtain informed consent/assent from all participants. Surveys will be administered in the comfort of the participant's home with a trained interviewer. Interviewers will be trained on sensitive questions and will remind participants that they can refuse to respond to any question they are not comfortable answering. Prior to the family interviews, interviewers will ask that respondents find a quiet place where they can talk freely, without distraction and to ensure no one else can listen in.

12. Provide estimates of the hour burden of the collection of information. The statement should:

- **indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices;**
- **if this request covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens; and**
- **provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories.**
- **The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 13.**

Estimated Number of Respondents: Mobility services staff will use the mobility services tracking tool as part of their case management system. The tool will also record data on service usage for the study. We estimate an average of 30 staff per year will collect data and add it to the tool. The follow-up assessments for the Child and the Obesity and Type II Diabetes Risk Assessments will be completed for an estimated 1,800 respondents. This consists of 900 parents or guardians and 900 children participating in the Obesity and Type II Diabetes Risk Assessment. We estimate that the Child Assessment will be administered to a subset of 837 families that also participate in the Obesity and Type II Diabetes Risk Assessment, so they are already included in the estimated number of respondents above.

Frequency of Response: For the mobility services tracking tool we expect each service staff to serve 21 households during the three-year approval period and use the tool to record information 8 times for each household, representing 168 responses during the three-year approval period,

representing an annual frequency of responses of 56. The Child and the Obesity and Type II Diabetes Risk Assessments follow-up instruments will be applied once during the three-year approval period, representing an annual frequency of responses of 0.33.

Annual Burden: The estimated total annual burden of this information collection is **46,601.34** hours. The estimated total annual cost for this information collection is $**297,200.44**. Most of the burden time (96%) and cost (91%) comes from accelerometers that are used by 400 adults and 400 children for seven days. We adopted an approach to count all 168 hours of continuous 7-day device wear (i.e. including sleep) as the respondent burden plus one hour to put on/return the device. Two hourly rates are used in this estimate:

3. For Service Delivery staff, the hourly cost of response of $30.28 is based on the average wage for counselors, social workers, and career counselors (as of May 2024, accessed March 30, 2026, at https://data.bls.gov/oes/#/industry/000000).
4. For Family Respondents, the hourly cost of response of $12.08 is based on the average 2026 hourly minimum wage rate for workers in the 8 study sites Los Angeles, Louisiana, Minnesota, New York State, New York City, Ohio, Pennsylvania, and Tennessee).[15]

Annualized cost estimates were not calculated for the child sample. The child sample eligible to participate in the study will be under the age of 18. Most, if not all, will be enrolled in school and working part-time at the most. Thus, we did not calculate an hourly wage for the child sample. Below is a breakdown of each assessment's data collection components.

Service Delivery Tracking Tool

In the mobility services tracking tool, we expect mobility service staff to use roughly 12 minutes, or 0.2 hours, per household to record service delivery information. This represents a total respondent burden of 1,008.00 hours.

Child Assessment

The Child Assessment includes the consent (8 minutes or .13 hours), a survey about the child (asked of parent/guardian) and parent/guardian's presence during direct child assessment (a total of 55 minutes or .92 hours), and a direct child assessment (32 minutes or .53 hours per child). This represents a total respondent burden of 95 minutes or 1.58 hours. Consent for the Child Assessment and the Obesity and Type II Diabetes Risk Assessment will be obtained at the same time, through the same instrument; we have apportioned the total time estimate for the combined instrument across the two assessments.

Obesity and Type II Diabetes Risk Assessment

The Obesity and Type II Diabetes Risk Assessment includes an advance letter (5 minutes or .08 hours), an email (1 minute or .02 hours), and a follow-up call from the research team (8 minutes or .13 hours). It also includes consent and enrollment (40 minutes or .67 hours); adult survey (85

[15] Los Angeles (effective 7/1/2026): https://dcba.lacounty.gov/workers/
New York City (effective 1/1/2026): https://www.ny.gov/new-york-states-minimum-wage/new-york-states-minimum-wage
Louisiana, Minnesota, New York, Ohio, Pennsylvania, Tennessee: 2026 Minimum Wage Rates by State

minutes or 1.42 hours); anthropometric assessments for adults (10 minutes or 0.17 hours) and children (10 minutes or 0.17 hours and 10 minutes or .17 hours for the parent or guardian who must also be present); and blood spot sample of the adult (10 minutes or 0.17 hours). The home observations/housing assessment will take 15 minutes (.25 hours). The accelerometer is expected to take adults and children one hour to put on and return. Returning the accelerometer will involve the participant placing the device in the self-addressed, postpaid return envelope that the interviewer provided and mailing it back to the study team. We also included the full burden of participants wearing the accelerometer for 7 days for a total burden of 169 hours. We expect the blood pressure reading to take 15 minutes or .25 hours. Finally, for the subset of 100 adults that are interviewed as part of the semi-structured interviews, consent is expected to take 10 minutes (or .17 hours) and the interviews are expected to take 90 minutes, or 1.5 hours. The Tracking emails/texts, to be administered twice during the follow-up period, are expected to take 8 minutes (.13 hours) and the tracking calls, to be administered three times during the follow-up period, are expected to take 10 minutes (.17 hours) to complete. The burden table reflects the evaluation team's estimate that it may need to conduct initial outreach, via emails, letters, and phone calls, to up to 1,285 families in order to recruit 900 families to participate in the Obesity and Type II Diabetes Risk Assessment.

Exhibit A.4: Annualized Burden Table

Information Collection	Number of Respondents	Frequency of Response	Responses Per Annum	Burden Hour Per Response	Annual Burden Hours	Hourly Cost Per Response	Annual Cost
Mobility Service Tracking Tool							
Mobility Service Tracking Tool	30	56.00	1,680.00	0.2	336.00	$30.28	$10,174.08
Child Assessment							
Consent for Assessment	837	0.33	276.21	0.13	35.91	$12.08	$433.79
Survey about child (asked of parent/guardian) and parent/guardian's presence during direct Child Assessment – Follow-up	837	0.33	276.21	0.92	254.11	$12.08	$3,069.65
Direct Child Assessment – Follow-up	837	0.33	276.21	0.53	146.39	n/a	n/a
Obesity and Type II Diabetes Risk Assessment							
Advance Letter	1,285	0.33	424.05	0.08	33.92	$12.08	$409.75
Email Reminder	1,285	0.33	424.05	0.02	8.48	$12.08	$102.44
Follow-up Call Phone Script	1,285	0.33	424.05	0.13	55.13	$12.08	$665.97
Consent for Assessment	900	0.33	297.00	0.67	198.99	$12.08	$2,403.80
Adult Survey – Follow-up	900	0.33	297.00	1.42	421.74	$12.08	$5,094.62

Anthropometric assessments – Follow-up (adult)	900	0.33	297.00	0.17	50.49	$12.08	$609.92
Anthropometric assessments – Follow-up (child)	900	0.33	297.00	0.17	50.49	n/a	n/a
Anthropometric assessments – Follow-up (child, but accounting for parent's time)	900	0.33	297.00	0.17	50.49	$12.08	$609.92
Blood Spot Samples (adult)	900	0.33	297.00	0.17	50.49	$12.08	$609.92
Home Observations/ Housing Assessment – Follow-up	900	0.33	297.00	0.25	74.25	$12.08	$896.94
Accelerometers – Follow-up (adult)	400	0.33	132.00	169	22,308.00	$12.08	$269,480.64
Accelerometers – Follow-up (child)	400	0.33	132.00	169	22,308.00	n/a	n/a
Blood Pressure Reading – Follow-up (adult)	900	0.33	297.00	0.25	74.25	$12.08	$896.94
Consent for Semi-Structured Interviews	100	0.33	33.00	0.17	5.61	$12.08	$67.77
Semi-Structured Interviews	100	0.33	33.00	1.5	49.50	$12.08	$597.96
Tracking Emails/Texts	900	0.33	297.00	0.13	38.61	$12.08	$466.41
Tracking Calls	900	0.33	297.00	0.17	50.49	$12.08	$609.92
Totals			**7,080.78**		**46,601.34**		**297,200.44**

13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information (do not include the cost of any hour burden shown in Items 12 and 14).

- **The cost estimate should be split into two components: (a) a total capital and start-up cost component (annualized over its expected useful life); and (b) a total operation and maintenance purchase of services component. The estimates should take into account costs associated with generating, maintaining, and disclosing or providing the information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s) and the time period over which costs will be**

incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities;

- **If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting our information collection services should be a part of this cost burden estimate. In developing cost burden estimates, agencies may consult with a sample of respondents (fewer than 10) utilize the 60-day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.**
- **Generally, estimates should not include purchases of equipment or services, or portions thereof made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.**

This data collection effort involves no recordkeeping or reporting costs for respondents other than the time burden to respond to questions on the data collection instruments as described in item A.12. There is no known cost burden to the respondents.

14. Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.

The data collection for the Mobility Service Tracking Tool is funded by HUD and will be carried out by Abt Global under a contract with HUD. The data collection for the Child Assessments is funded by HUD and will be carried out by JHU under a subcontract with Abt Global. The data collection for the Obesity and Type II Diabetes Risk Assessment is funded by a grant to JHU from the National Institute of Diabetes and Digestive and Kidney Diseases as part of the MOVED study. Data collection for this effort will be carried out by JHU. HUD estimates the total cost to the Federal government of the data collection effort over the three-year term of this information collection to be approximately $525,000 (see Exhibit A.5).

The professional labor includes the labor hours required to maintain the mobility service tracking tool for one year and to implement the follow-up data collection of the Child Assessment in the next two years. The labor hours also include time to process mobility service data and the responses to the child survey efforts. This includes the cost related to salaries of Abt Global employees, hours for subcontracted interviewers, and operational expenses such as developing the web-based data collection system, translation costs, and mailing and shipping costs. The Obesity and Type II Diabetes Risk Assessment does not have a cost to the Federal government because the data collection is funded by a grant to JHU from the National Institute of Diabetes and Digestive and Kidney Diseases as part of the MOVED study.

The total incentive fees anticipated to be paid are based on the expected response rate and the incentive to be offered for each outreach effort.

Exhibit A.5: Estimated Annual Cost to the Federal Government

Activity	Estimated Cost to Federal Government
Mobility Service Tracking Tool	$75,000
Child Assessment	$450,000
Obesity and Type II Diabetes Risk Assessment, first three years	$0
Total costs over the request period	**$525,000**
Annual costs per year	**$175,000**

15. Explain the reasons for any program changes or adjustments.

This is an extension of an approved information collection. Under OMB Control #2528-0337, OMB approved the information collection to support the enrollment of families into the Demonstration, along with instruments to support a series of qualitative interviews with key stakeholders in the Demonstration, and cost data collection components, in May and June 2022. On October 6, 2022, OMB approved non-substantive changes to this information collection. On December 18, 2023, OMB approved a revision to the collection to add three studies: the Home Assessment, the Child Assessment, and the Obesity and Diabetes Risk Assessment. On March 27, 2024, October 22, 2024, and May 28, 2025, OMB approved additional non-substantive changes to select instruments. Approval for those previously approved instruments is valid through December 31, 2026.

In 2024, HUD cancelled the Home Assessment study because of lower-than-expected enrollments, the withdrawal of one of the two sites implementing this study, and new research that questioned the study's ability to detect impact with the proposed methodology.

On June 30, 2026, the Demonstration ended enrollment in the study. The study also completed all qualitative and cost study interviews in 2025. The following previously approved instruments will be discontinued after December 31, 2026: (1) Household Roster and Baseline Information

Form; (2) Baseline Survey; (3) PHA Staff Interview Guide; (4) Mobility Service Providers Interview Guide; (5) Interview Guide for Participating Families Currently Searching for Housing; (6) Interview Guide for Participating Families Who Have Leased Up; (7) Interview Guide for Opportunity Area Landlords; and (8) Cost Data Collection Interview Guide.

This extension request includes a subset of previously approved instruments. The Mobility Service Tracking Tool will be operational, and the data will be used for another year to complete analysis for a final report. The Child Assessment and the Obesity and Type II Diabetes Risk Assessment will be used for three more years to complete follow-up data collection and analysis for final reports.

This request includes limited changes to the content of those instruments that do not affect the original scope, design, and burden estimates of the previously approved data collection. The primary purposes of these changes are to 1) add clarity and comprehension and adding "follow-up" to the title; and 2) improve the quality and accuracy of the data collection. Attachment T provides a summary and justification of the changes made to each instrument.

Finally, this request includes small increases to the incentive amount to ensure that families are adequately compensated for their time and effort in participating in the study. The IRB reviewed and concurred with the proposed changes. Exhibit A.6 explains the planned changes to respondent incentives.

Exhibit A.6: Planned Changes to Respondent Incentives

Child Assessment – Follow-up	Increased the follow-up incentive from $25 to $35
Obesity and Type II Diabetes Risk Assessment survey – Follow-up (adult)	Maintained the original follow-up incentive of $70, but added a separate incentive of $20 for the follow-up Anthropometric Assessment (see line below)
Obesity and Type II Diabetes Risk Assessment Anthropometric Assessment – Follow-up (adult)	Added a $20 incentive for this part of the follow-up adult survey
Obesity and Type II Diabetes Risk Assessment Anthropometric Assessment – Follow-up (child)	Increased the follow-up incentive from $10 to $20
Obesity and Type II Diabetes Risk Assessment Blood spot samples – Follow-up	Maintained the original follow-up incentive of $25
Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment – Follow-up (adult)	Increased the follow-up incentive from $25 to $35
Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment – Follow-up (child)	Increased the follow-up incentive from $25 to $35
The Obesity and Type II Diabetes Risk Assessment: Blood pressure readings –Follow-up	Maintained the original follow-up incentive of $15
Semi-structured interviews for subset of Obesity and Type II Diabetes Risk Assessment	Increased the original incentive from $75 to $100

16. For collection of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.

The planned impact analyses rely on data collected under this information collection request. This section first provides an overview of the data collection schedule, with the projected timing of each activity. The section then shows the timing for the publication plans that will be conducted in support of the Demonstration evaluation. The details on the analysis plans and report content are described in Supporting Statement B.

Exhibit A.7 shows the timing for the data to be collected under this information collection request and related reports.

Exhibit A.7*:* Data Collection and Report Schedule

Milestone	Timing
End Data Collection in the Mobility Service Tracking Tool	January 2027
Final Report for the Community Choice Demonstration (4-year impact)	December 2027
Begin Follow-up Data Collection for Child and Obesity and Type II Diabetes Risk Assessments	September 2026
End Data Collection for Child Assessment	March 2028
Final Report for Child Assessment	September 2028
End Data Collection for Obesity and Type II Diabetes Risk Assessment	October 2028
Peer-reviewed articles based on the Obesity and Type II Diabetes Risk Assessment	January 2029

Mobility Service Tracking Tool

The Final Report for the Community Choice Demonstration will integrate the results of the impact (quantitative), process (qualitative) and cost analyses for all families enrolled in the Demonstration, summarizing findings on all research questions (RQ). The report will include an analysis of the Mobility Service Tracking Tool data to help address exploratory research questions on services within the CMRS that appear most effective in facilitating moves to opportunity areas and the successes and challenges of program implementation.

Child Assessment

The Child Assessment Report will provide a summary of impact analyses conducted on the effects of CMRS on children's mental health, behavior, physical health, social functioning, executive functioning, and educational outcomes, as well as on parenting practices.

Impact analyses will be conducted using largely similar methods as those used for the Phase 1 Impact Evaluation Report for the Demonstration. Child Assessment impact analyses will additionally include analysis weights to account for (1) the probability of selection as a focal child within the household, (2) non-response at follow-up, and (3) any baseline characteristics on which the sample that enrolls into the Child Assessment study is non-equivalent. The report will also summarize any differences in effects by children's age and sex identified. The report will briefly summarize prior research on the relationship between mobility and child outcomes, provide an overview of the research questions, include sections answering each of the research questions, and conclude with an integrative summary, including how findings from the child assessment may relate to findings from other planned Demonstration reports. A technical appendix will include a brief summary of the analysis methods and detailed impact analysis tables for analyses conducted.

Obesity and Type II Diabetes Risk Assessment

In one or more peer-reviewed articles, JHU researchers will analyze the impacts of being offered CMRS on BMI and HbA1c (adults) and BMI z-score (children). The articles will also examine behavioral, psychosocial, contextual, and structural factors along the causal pathway. The primary analytic approach will use an intention-to-treat framework and, in secondary analyses, will account for intervention take-up. In addition, the articles will analyze in-depth interview data from approximately 75 adults to examine mechanisms through which moving to a more affluent neighborhood impacts obesity and type II diabetes risk.

17. If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

Not applicable — HUD is not seeking an exception; all data collection instruments will prominently display the expiration date for OMB approval.

18. Explain each exception to the topics of the certification statement identified in "Certification for Paperwork Reduction Act Submissions."

No exceptions.