Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Virtual Meeting).

Contact Person: Marie-Jose Belanger, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5181, MSC, Bethesda, MD 20892, *belangerm@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Biological Chemistry, Biophysics, and Drug Discovery.

Date: November 8, 2012.

Time: 8:30 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Doubletree Hotel Bethesda, (Formerly Holiday Inn Select), 8120 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Sergei Ruvinov, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4158, MSC 7806, Bethesda, MD 20892, 301–435–1180, *ruvinser@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Biological Chemistry, Biophysics, and Drug Discovery.

Date: November 8, 2012.

Time: 10 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892.

Contact Person: Dennis Hlasta, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6185, MSC, Bethesda, MD 20892, 301–435–1047, *dennis.hlasta@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR–11–100: Alzheimer's Disease Pilot Clinical Trials.

Date: November 8, 2012.

Time: 1 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Virtual Meeting).

Contact Person: Mark Lindner, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3182, MSC 7770, Bethesda, MD 20892, 301–435–0913, *mark.lindner@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; AREA: Endocrinology, Metabolism, Nutrition and Reproduction.

Date: November 8, 2012.

Time: 1 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Virtual Meeting).

Contact Person: Dianne Hardy, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6175, Bethesda, MD 20892, 301–435–1154, *dianne.hardy@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Neural Injury and Neurodegeneration.

Date: November 8, 2012.

Time: 1:30 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Seetha Bhagavan, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5194, MSC 7846, Bethesda, MD 20892, (301) 237–9838, *bhagavas@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Language and Communication.

Date: November 8, 2012.

Time: 12 p.m. to 2:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Serena Chu, Ph.D., Scientific Review Officer, BBBP IRG, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3178, MSC 7848, Bethesda, MD 20892, 301–500–5829, *sechu@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: October 3, 2012.

David Clary,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2012–24877 Filed 10–9–12; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project: Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant FY 2014–2015 Application Guidance and Instructions (OMB No. 0930–0168)—Revision

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting approval from the Office of Management and Budget (OMB) for a revision of the 2014 and 2015 Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) Guidance and Instructions into a uniform block grant application.

Currently, the SABG and the MHBG differ on a number of their practices (e.g., data collection at individual or aggregate levels) and statutory authorities (e.g., method of calculating MOE, stakeholder input requirements for planning, set asides for specific populations or programs, etc.). Historically, the Centers within SAMHSA that administer these block grants have had different approaches to application requirements and reporting. To compound this variation, states have had different structures for accepting, planning, and accounting for the block grants and the prevention set aside within the SABG. As a result, how these dollars are spent and what is known about the services and clients that receive these funds varies by block grant and by state.

In addition, between 2014 and 2015, 32 million individuals who are uninsured will have the opportunity to enroll in Medicaid or private health insurance. This expansion of health insurance coverage will have a significant impact on how State Mental Health Authorities (SMHAs) and State Substance Abuse Authorities (SSAs) use their limited resources. Many individuals served by these authorities are funded through federal block grant funds. SAMHSA proposes that block grant funds be directed toward four purposes: 1) to fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; 2) to fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery; 3) to fund universal, selective and targeted prevention activities and services; and 4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery

support services and to plan the implementation of new services on a nationwide basis.

States should begin planning now for FY 2014 when more individuals will have additional opportunities to be insured. To ensure sufficient and comprehensive preparation, SAMHSA will use FY 2013 to continue to work with states to plan for and transition the Block Grants to these four purposes. This transition includes fully exercising SAMHSA's existing authority regarding states' and jurisdictions' (subsequently referred to as ''states'') use of block grant funds, and a shift in SAMHSA staff functions to support and provide technical assistance for states receiving block grant funds as they move through these changes.

The proposed MHBG and SABG build on ongoing efforts to reform health care, ensure parity and provide states with new tools, new flexibility, and state/territory-specific plans for available resources to provide their residents the health care benefits they need. The planning section of the block grant application provides a process for states to identify priorities for individuals who need behavioral health services in their jurisdictions, develop strategies to address these needs, and decide how to expend block grant funds. In addition, the planning section of the block grant requests additional information from states that could be used to assist them in their reform efforts. The plan submitted by each state will provide information for SAMHSA and other federal partners to use in working with states to improve their behavioral health systems over the next two years as health care and economic conditions evolve.

The FY 2014–2015 block grant application provides states the flexibility to submit one rather than two separate block grant applications if they choose. It also allows states to develop and submit a bi-annual rather than an annual plan, recognizing that the demographics and epidemiology do not often change on an annual basis. These options may decrease the number of applications submitted from four in two years to one.

Over the next several months, SAMHSA will assist states (individually and in smaller groups) as they develop their block grant applications. While there are some specific statutory requirements that SAMHSA will look for in each submitted application, SAMHSA intends to approach this process with the goal of assisting states in setting a clear direction for system improvements over time, rather than as a simple effort to seek compliance with minimal requirements.

Consistent with previous applications, the FY 2014–2015 application has sections that are required and other sections where additional information is requested, but not required. The FY 2014–2015 application requires states to submit a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, executive summary, and funding agreements, assurances, and certifications. In addition, SAMHSA is requesting information on key areas that are critical to the state's success in addressing health reform and parity. States will continue to receive their annual grant funding if they only chose to submit the required section of their state plans or choose to submit separate plans for the MHBG or SABG. Therefore, as part of this block grant planning process, SAMHSA is asking states to identify their technical assistance needs to implement the strategies they identify in their plans for FY 2014 and 2015.

To facilitate an efficient application process for states in FY 2014–2015, SAMHSA convened an internal workgroup to develop the block grant planning section. In addition, SAMHSA consulted with representatives from the State Mental Health and State Substance Abuse Authorities to receive input regarding proposed changes to the block grant. Comments were requested from federal partners including the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), the Office of National Drug Control Policy (ONDCP), and the Assistant Secretary for Financial Resources (ASFR). Other stakeholder groups consulted with included NASADAD and NASMHPD. Based on these discussions with states, federal partners, and stakeholder groups, SAMHSA is proposing the following revisions to the block grant application.

Changes to Assessment and Planning Activities

SAMHSA has not made major revisions to the FY 2014–2015 application. The proposed revisions are based primarily on previous instructions provided in the FY 2012–2013 application guidance. In building on the FY 2012–2013 guidance, SAMHSA proposed revisions to expand the areas of focus (environmental factors) for states to describe their comprehensive plans to provide treatment, services, and supports for individuals with behavioral health needs. These revisions will enable SAMHSA to assess the extent to which states plan for and implement provisions of the Affordable Care Act and determine whether block grants funds are being directed toward the four purposes of the grant.

The proposed revisions reflect changes within the planning section of the application. The most significant of these changes relate to prevention, particularly primary prevention; data and quality; enrollment of individuals and providers; and descriptions of good and modern behavioral health services. States are encouraged to address each of the focus areas. SAMHSA has provided a set of guiding questions to stimulate and direct the dialogue that states may engage in to determine the various approaches used to develop their responses to each of the focus areas.

The proposed revisions are described below:

Areas of Focus/Environmental Factors

- *Coverage for M/SUD Services*—Beginning in 2014, block grant dollars should be used to pay for (1) people who are uninsured, (2) services that are not covered by insurance and Medicaid, (3) prevention, and (4) the collection of performance and outcome data. Presumably, there will be similar concerns at the state level that state dollars are being used for people and/or services not otherwise covered. States (or the federal exchange) are currently making plans to implement the benchmark plan chosen for Qualified Health Plans (QHPs) and their expanded Medicaid program. States should begin to develop strategies that will monitor the implementation of the Act in their states. States should begin to identify whether people have better access to mental health and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering services for mental and substance abuse disorders and whether services are offered consistent with provisions of MHPAEA.
- *Affordable Insurance Exchanges*—Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to much needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system. They should also understand how insurers (commercial, Medicaid and Medicare plans) will be making decisions regarding their provider networks. States should consider

developing benchmarks regarding the expected number of individuals in their publicly funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set targets or recommendations for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

• *Program Integrity* —The Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside the Exchanges, Medicaid benchmark and benchmark equivalent plans, and basic health programs must cover these EHBs. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a ''typical employer plan'' in a state as required by the Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should be focused on two main areas related to EHBs: monitoring what is covered and aligning block grants and state funds for what is not covered. These include: 1) ensuring that QHPs and Medicaid programs are including EHBs as per the state benchmark plan; 2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; 3) ensuring that people will utilize the benefits despite concerns that employers will learn of mental health and substance abuse diagnosis of their employees; and 4) monitoring utilization of mental health and substance abuse benefits in light of utilization review, medical necessity, etc.

SAMHSA expects states to implement policies and procedures that are designed to ensure that block grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also need to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

• *Use of Evidence in Purchasing Decisions*—SAMHSA is interested in whether or how states are using evidence in their purchasing decisions, educating policymakers or supporting providers to offer high quality services. In addition, SAMHSA is interested in additional information that is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services.

• *Quality*—Up to 25 data elements, including those in the table below will be available through the Behavioral Health Barometer which SAMHSA will prepare at least bi-annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas. States will receive feedback on an annual basis in terms of national, regional and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the block grant funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance abuse treatment	Mental health services
Health	Youth and Adult Heavy Alcohol Use—Past 30 Day.	Reduction/No Change In substance use past 30 days.	Level of Functioning.
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing.
Community	Environmental Risk/Exposure to Prevention Messages And/or Friends Disapproval.	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population.
Purpose	Pro-Social Connections-Community Connections.	Percent in TX employed, in school, etc.—TEDS.	Clients w/SMI or SED who are employed, or in school.

• *Trauma*—In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies such as exposure therapy or trauma-focused cognitive behavioral approaches should be adopted to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma informed care approach consistent with SAMHSA's trauma informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

• *Justice*—The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-arrest, pre-adjudication and pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: Drug courts and mental health courts. However, there are a number of different types of problem-solving courts. In addition to drug courts and mental health courts, some jurisdictions, for example, operate courts for DWI/DUI, veterans, family, teen, reentry, as well as courts such as gambling, domestic violence, truancy, etc. States are also encouraged to work with municipalities to determine whether municipal mental health or drug courts might be viable. Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes can be emphasized. States should place emphasis on screening, assessment, and services provided prior to arrest, adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. Secondarily, states should examine specific barriers such as lack of identification needed for enrollment, loss of eligibility resulting from incarceration, and care coordination for individuals with chronic health conditions, housing

instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives for detention.

• *Parity Education*—SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

• *Primary and Behavioral Health Care Integration Activities*—Numerous provisions in the Affordable Health Care Act and elsewhere improve the coordination of care for patients through the creation of health homes, where teams of health professionals will be rewarded to coordinate care for patients with chronic conditions. States that had approved Medicaid State Plan Amendments (SPAs) received 90 percent Federal Medicaid Assistance Percentage (FMAP) for health home services for eight quarters. At this critical point in time, some states are ending their two years of enhanced FMAP and rolling back to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects. States should indicate how these changes and opportunities affect their application.

• *Health Disparities*—In the block grant application, states are asked to define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services; American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community; and African American women may be at greater risk for contracting HIV/AIDS due lack of access to education on risky sexual behaviors in urban low-income communities, etc. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served and not being served within their communities, including in what languages services are provided, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services and outcomes are critical measures of quality and outcomes of care for diverse groups. In order to address the potentially disparate impact for their block grant funded efforts, states will be asked to address access, use and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection and sexual orientation (i.e., lesbian, gay, bisexual).

• *Recovery*—SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from mental or substance use disorders.

• *Children and Adolescents Behavioral Health Services*—Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the System of Care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities. Every state has received at least one CMHI grant. In 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to build a state infrastructure for substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidenced-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential (e.g., wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance use disorder intensive out patient services, continuing care, mobile crisis response, etc.), supportive services (e.g., peer youth support, family peer support, respite services, mental health consultation, supported education and employment, etc.), and residential services (e.g., therapeutic foster care, crisis stabilization services, inpatient medical detoxification, etc.).

Although the statutory dates for submitting the block grant application, plan and annual report remain unchanged, SAMHSA requests that the MHBG and SABG applications be submitted on the same date. In addition, the dates for submitting the plans have changed to better comport with most states fiscal and planning years (July 1st through June 30th of the following year).

Application(s) for FY	Application due	Plan due	Planning period	Reports due
2014	4/1/13	Yes	7/1/13–6/30/15	12/1/13
2015	4/1/14	No		12/1/14
2016	4/1/15	Yes	7/1/15–6/30/17	12/1/15
2017	4/01/16	No		12/1/16

Summary of Changes as a Result of the 60-Day ***Federal Register*** *Notice*

SAMHSA received 232 comments from 36 individuals or organizations. The comments expressed general support for the option to submit a combined plan for mental and substance use disorders (M/SUD) for both block grants, the movement to the behavioral health barometer, the expressed four priorities for the block grants, the two-year planning cycle, and tribal consultation. Many comments were duplicative and include requests that SAMHSA eliminate any reference to

initiatives in the President's budget proposal and include a discussion of only those initiatives that are authorized; ask only for what is required information and not include any areas that are requested; clarify that SABG dollars cannot be used for mental health promotion; provide clear operational definitions for each outcome measure; simplify the data collected; reduce or clarify the expanded area of focus; change the acronym for the substance abuse block grant back to SAPTBG; address a concern from some states that the April 1 deadline will be difficult given other priority activities in the states; emphasize older adults and veterans; require substance abuse representation on the planning council for those states submitting a combined application; and, address a concern that the use of block grant funds are becoming more prescriptive instead of giving states maximum flexibility.

SAMHSA received some comments about the ''Behavioral Health Advisory Council Composition by Member Type'' table indicating that the reference to members from diverse racial and LGBTQ populations is potentially confusing and creates a dilemma as to which category members should be ascribed, the term 'leading state experts' is also confusing and somewhat arbitrary, and the membership categorization for ''Federally Recognized Tribe Representatives'' could be confused with council members who happen to be tribal members. SAMHSA agrees with the recommendations that the request for a number of individuals and providers from diverse racial, ethnic, and LGBTQ backgrounds in the table will skew the calculation of the percentage of consumers/state members. SAMHSA has moved this information request, as well as the request to identify any member who is an individual in recovery from SUD or advocating for SUD services to the bottom of the table and removed it from the calculation. ''Leading state expert'' is deleted. Federally Recognized Tribal Representatives are individuals who are officially designated by the tribe to sit on the Council.

SAMHSA added clarifying language within the prevention section, that clarifies that states will be allowed to use some of their current Mental Health Block Grant to support mental health promotion and mental illness prevention activities related to adults with serious mental illnesses and children with serious emotional disturbances and their families. In addition, the 20% set aside funds of the Substance Abuse Block Grant must be used for substance abuse primary prevention activities by the state. Many evidenced-based substance abuse programs have a positive impact on the prevention of substance use and abuse as well as other health and social outcomes such as education, juvenile justice involvement, violence prevention and mental health.

SAMHSA reduced the number of questions in the prevention planning section, in the Primary and Behavioral Health Care Integration Activities section, and in the Technical Assistance needs section..

SAMHSA has renumbered and, in some instances, renamed tables throughout the document to eliminate the redundancy in the table numbers between the planning and reporting sections and improve user navigation. SAMHSA also revised the table entitled 'Behavioral Health Advisory Council Composition by Member Type.' In addition, SAMHSA enhanced the tables of contents in the reporting sections to facilitate user navigation.

Estimates of Annualized Hour Burden

The estimated annualized burden for a uniform application is 37,429 hours. Burden estimates are broken out in the following tables showing burden separately for Year 1 and Year 2. Year 1 includes the estimates of burden for the uniform application and annual reporting. Year 2 includes the estimates of burden for the application update and annual reporting. The reporting burden remains constant for both years.

TABLE 1—ESTIMATES OF APPLICATION AND REPORTING BURDEN FOR YEAR 1

Application element	Number respondents	Responses/ respondents	Burden/ response (hours)	Total burden
Application Burden				
Yr One Plan (separate submissions)	30 (CMHS) 30 (SAPT)	1	282	16,920
Yr One Plan (combined submission)	30	1	282	8,460
Application Sub-total	60			25,380
Reporting Burden				
MHBG Report	59	1	186	10,974
URS Tables	59	1	35	2,065
SABG Report	[1]60	1	186	11,160
Table 5	[2]15	1	4	60
Reporting Subtotal	60			24,259
Total	119			49,639

[1] Redlake Band of the Chippewa Indians from MN receives a grant.
[2] Only 15 States have a management information system to complete Table 5.

TABLE 2—ESTIMATES OF APPLICATION AND REPORTING BURDEN FOR YEAR 2

Application element	Number respondents	Responses/ respondents	Burden/ response (hours)	Total burden
Application Burden				
Yr Two Plan	24	1	40	960
Application Sub-total	24			960
Reporting Burden				
MHBG Report	59	1	186	10,974
URS Tables	59	1	35	2,065
SABG Report	60	1	186	11,160
Table 5	15	1	4	60
Reporting Subtotal	60			24,259
Total	119			25,219

The total annualized burden for the application and reporting is 37,429 hours (49,639 + 25,219 = 74,858/2 years = 37,429).

Link for the application: *www.samhsa.gov/grants/blockgrant.*

Written comments and recommendations concerning the proposed information collection should be sent by November 9, 2012 to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via email to: *OIRA_Submission@omb.eop.gov.* Although commenters are encouraged to send their comments via email, commenters may also fax their comments to: 202–395–7285. Commenters may also mail them to: Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 10102, Washington, DC 20503.

Summer King,

Statistician.

[FR Doc. 2012–24862 Filed 10–9–12; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4078–DR; Docket ID FEMA–2012–0002]

Oklahoma; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Oklahoma (FEMA–4078–DR), dated August 22, 2012, and related determinations.

DATES: *Effective Date:* September 27, 2012.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Oklahoma is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of August 22, 2012.

Cleveland County for Individual Assistance.

(The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households in Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.)

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2012–24718 Filed 10–9–12; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5613–N–10]

Privacy Act of 1974; Home Equity Reverse Mortgage Information Technology (HERMIT)—Notice of Modification to, and Deletion of HUD/HS–10, Home Equity Conversion Mortgage System

AGENCY: Office of the Chief Information Officer HUD.

ACTION: Notification of modification to, and deletion of existing system of records notification.

SUMMARY: Pursuant to the provision of the Privacy Act of 1974, as amended (5 U.S.C. 552a), the Department of Housing and Urban Development (HUD) is providing notice of its intent to modify and delete one of its system of records notifications, the HUD/HS–10, Home Equity Conversion Mortgage (HECM) system. HUD/HS–10, HECM is being modified and replaced by the new HECM program system, Home Equity Reverse Mortgage Information Technology (HERMIT). The modifications for the existing system of