areas (HPSAs) as of May 1, 2018. The lists are available on HRSA's HPSAFind website.

ADDRESSES: Complete lists of HPSAs designated as of May 1, 2018, are available on the HPSAFind website at *https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx.* Frequently updated information on HPSAs is available at *http://datawarehouse.hrsa.gov.* Information on shortage designations is available at *https://bhw.hrsa.gov/shortage-designation.*

FOR FURTHER INFORMATION CONTACT: For further information on the HPSA designations listed on the HPSAFind website or to request additional designation, withdrawal, or reapplication for designation, please contact Melissa Ryan, Acting Director, Division of Policy and Shortage Designation, Bureau of Health Workforce, HRSA, 11SWH03, 5600 Fishers Lane, Rockville, Maryland 20857, (301) 594–5168 or *MRyan@hrsa.gov.*

SUPPLEMENTARY INFORMATION:

Background

Section 332 of the Public Health Service (PHS) Act, 42 U.S.C. 254e, provides that the Secretary shall designate HPSAs based on criteria established by regulation. HPSAs are defined in section 332 to include (1) urban and rural geographic areas with shortages of health professionals, (2) population groups with such shortages, and (3) facilities with such shortages. Section 332 further requires that the Secretary annually publish lists of the designated geographic areas, population groups, and facilities. The lists of HPSAs are to be reviewed at least annually and revised as necessary.

Final regulations (42 CFR part 5) were published in 1980 that include the criteria for designating HPSAs. Criteria were defined for seven health professional types: Primary medical care, dental, psychiatric, vision care, podiatric, pharmacy, and veterinary care. The criteria for correctional facility HPSAs were revised and published on March 2, 1989 (54 FR 8735). The criteria for psychiatric HPSAs were expanded to mental health HPSAs on January 22, 1992 (57 FR 2473). Currently-funded PHS Act programs use only the primary medical care, mental health, or dental HPSA designations.

HPSA designation offers access to potential federal assistance. Public or private nonprofit entities are eligible to apply for assignment of National Health Service Corps (NHSC) personnel to provide primary medical care, mental health, or dental health services in or to these HPSAs. NHSC health professionals enter into service agreements to serve in federally designated HPSAs. Entities with clinical training sites located in HPSAs are eligible to receive priority for certain residency training program grants administered by HRSA's Bureau of Health Workforce (BHW). Other federal programs also utilize HPSA designations. For example, under authorities administered by the Centers for Medicare and Medicaid Services, certain qualified providers in geographic area HPSAs are eligible for increased levels of Medicare reimbursement.

Content and Format of Lists

The three lists of designated HPSAs are available on the HPSAFind website and include a snapshot of all geographic areas, population groups, and facilities that were designated HPSAs as of May 1, 2018. This notice incorporates the most recent annual reviews of designated HPSAs and supersedes the HPSA lists published in the **Federal Register** on June 26, 2017 (**Federal Register**/Vol. 82, No. 121/Monday, June 26, 2017/Notices 28863).

In addition, all Indian Tribes that meet the definition of such Tribes in the Indian Health Care Improvement Act of 1976, 25 U.S.C. 1603(d), are automatically designated as population groups with primary medical care and dental health professional shortages. Further, the Health Care Safety Net Amendments of 2002 provides eligibility for automatic facility HPSA designations for all federally qualified health centers (FQHCs) and rural health clinics that offer services regardless of ability to pay. Specifically, these entities include FQHCs funded under section 330 of the PHS Act, FQHC Look-Alikes, and Tribal and urban Indian clinics operating under the Indian Self-Determination and Education Act of 1975 (25 U.S.C. 450) or the Indian Health Care Improvement Act. Many, but not all, of these entities are included on this listing. Absence from this list does not exclude them from HPSA designation; facilities eligible for automatic designation are included in the database when they are identified.

Each list of designated HPSAs is arranged by state. Within each state, the list is presented by county. If only a portion (or portions) of a county is (are) designated, a county is part of a larger designated service area, or a population group residing in a county or a facility located in the county has been designated, the name of the service area, population group, or facility involved is listed under the county name. A county that has a whole county geographic HPSA is indicated by the phrase ''Entire county HPSA'' following the county name.

Development of the Designation and Withdrawal Lists

Requests for designation or withdrawal of a particular geographic area, population group, or a facility as a HPSA are received continuously by BHW. Under a Cooperative Agreement between HRSA and the 54 state and territorial Primary Care Offices (PCOs), PCOs conduct needs assessments and submit the majority of the applications to HRSA to designate areas as HPSAs. BHW refers requests that come from other sources to PCOs for review. In addition, interested parties, including Governors, State Primary Care Associations, and state professional associations, are notified of requests so that they may submit their comments and recommendations.

BHW reviews each recommendation for possible addition, continuation, revision, or withdrawal. Following review, BHW notifies the appropriate agency, individuals, and interested organizations of each designation of a HPSA, rejection of recommendation for HPSA designation, revision of a HPSA designation, and/or advance notice of pending withdrawals from the HPSA list. Designations (or revisions of designations) are effective as of the date on the notification from BHW and are updated daily on the HPSAFind website. The effective date of a withdrawal will be the next publication of a notice regarding the list in the **Federal Register**.

Dated: June 26, 2018.

George Sigounas,

Administrator.

[FR Doc. 2018–14115 Filed 6–29–18; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS–0990—new]

Agency Information Collection Request; 60-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before August 31, 2018.

ADDRESSES: Submit your comments to *Sherrette.Funn@hhs.gov* or by calling (202) 795–7714.

FOR FURTHER INFORMATION CONTACT: When submitting comments or requesting information, please include the document identifier 0990–New–60D and project title for reference., to *Sherrette.Funn@hhs.gov,* or call the Reports Clearance Officer.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collection: SMARTool Pilot Replication Project.

Type of Collection: OMB No. 0990–NEW—Office of the Assistant Secretary for Health (OASH).

Abstract: The Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services (HHS), is requesting approval by OMB of a new information collection request. OASH is updating the Center for Relationship Education's Systematic Method for Assessing Risk-Avoidance Tool (SMARTool), a tool for sexual risk avoidance (SRA) curriculum developers and implementing organizations (IOs) to ensure that their SRA curricula are grounded in evidence. In an effort to assess the SMARTool's impact, OASH aims to conduct a formative evaluation to (1) provide preliminary evidence on the effectiveness of SRA curricula that are aligned with the SMARTool, (2) derive lessons learned to improve the implementation of SRA curricula, and (3) develop and test baseline and follow-up questionnaires that assess SRA program effects on the key SMARTool constructs. The evaluation will be conducted with an estimated four IOs. The evaluation will use quantitative and qualitative methods and will include both a process evaluation and an outcome evaluation.

Need and Proposed Use of the Information: To enhance the rigor of the evaluation, a comparison group will be identified for each IO, if possible. This would enable an assessment of whether any changes identified in individual and contextual risk and protective factors in the intervention group differ from those in the comparison group. The process evaluation will describe in detail each IO's program, how it was delivered, and factors that may have influenced the success of the program's implementation. Process evaluation data are necessary for the interpretation of outcome findings and to inform efforts to improve program implementation. Depending on their performance on measures of reliability and validity, the baseline and follow-up questionnaires may be made available to organizations planning to evaluate curricula that are aligned with the SMARTool.

Likely respondents: Respondents will include participants in each of the IOs' SRA programs (9th or 10th grade youth), their parent(s), program facilitators, representatives of schools participating in the program (*e.g.,* school principals), and school or school district administrative staff.

EXHIBIT 1—TOTAL ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (hours)
Outcome Evaluation					
Parents	Parental consent	2,356	1	5/60	196
High school students	Youth Assent	2,356	1	5/60	196
	Baseline survey	2,356	1	30/60	1178
	Follow-up survey	2,120	1	30/60	1060
School or school district administrative staff.	Classroom roster report	24	1	120/60	48
Process Evaluation					
Program Facilitators	Process Evaluation Facilitator Session Log.	48	20	15/60	240
Program Facilitators	Process Evaluation Facilitator Survey.	38	1	25/60	16
High school students	Process Evaluation Participant Survey.	1,060	1	10/60	177
Program facilitators, site representatives.	Process Evaluation Key Informant Interviews.	24	1	60/60	24
Teachers	Attendance form	48	20	5/60	80
Total burden					3,135

Terry Clark,

Asst Information Collection Clearance Officer, Office of the Secretary.

[FR Doc. 2018–14203 Filed 6–29–18; 8:45 am]

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