Disorders Research, National Institutes of Health, HHS)

Dated: July 10, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–19069 Filed 7–16–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Closed Meetings

Purusant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisons set forth in section 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, ZDK1 GRB–8 02.

Date: July 22–24, 1998.

Time: July 22, 1998, 7:00 pm to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Hotel, 625 El Camino Real, Palo Alto, CA 94301–2380.

Contact Person: Robert J. Haber, Phd, Scientific Review Administrator, Review Branch, DEA, NIDDK, Natcher Building, Room 6AS–37, National Institutes of Health, Bethesda, MD 20892–6600, (301) 594–8898.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, ZDK1 GRB–D (01).

Date: July 27, 1998.

Time: 10:00 am to adjournment.

Agenda: To review and evaluate grant applications.

Place: Sheraton Crystal City Hotel, 1800 Jefferson Davis Highway, Arlington, VA 22202.

Contact Person: Ann Hagan, Chief, Review Branch, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, Phs, Dhhs, Rm. 6as37, Bldg. 45, Bethesda, MD 20892, (301) 594–8886.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institute of Health, HHS)

Dated: July 10, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–19070 Filed 7–16–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, International Drug Abuse Epidemiology Data Bank.

Date: July 17, 1998.

Time: 9:00 am to 5:00 pm.

Agenda: To review and evaluate contract proposals.

Place: National Institute on Drug Abuse, 5600 Fishers Lane, Room 10–49, Rockville, MD 20857 (Telephone Conference Call).

Contact Person: Eric Zatman, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, 10–42, Rockville, MD 20857, (301) 443–1644.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Neurological Effects of Drug Addiction Therapies.

Date: August 3, 1998.

Time: 8:30 am to 5:00 pm.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: Kesinee Nimit, MD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–22, Rockville, MD 20857, (301) 443–9042.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: July 10, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–19071 Filed 7–16–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Children With Serious Emotional Disturbance; Estimation Methodology

AGENCY: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Final notice.

SUMMARY: This notice describes the final methodology to identify and estimate the number of children with a serious emotional disturbance (SED) within each State. This notice is being published as part of the requirements of Public Law 102–321, the ADAMHA Reorganization Act of 1992.

EFFECTIVE DATE: October 1, 1998.

Background

Public Law 102–321, the ADAMHA Reorganization Act of 1992, amended the Public Health Service Act and created the Substance Abuse and Mental Health Services Administration (SAMHSA). The Center for Mental Health Services (CMHS) was established within SAMHSA to coordinate Federal efforts in the prevention and treatment of mental illness, and the promotion of mental health. Title II of Public Law 102–321 establishes a Block Grant for Community Mental Health Services, administered by CMHS, that permits the allocation of funds to States for the provision of community mental health services for children with a SED and adults with a serious mental illness (SMI). Public Law 102–321 stipulates that States estimate the incidence (number of new cases) and prevalence (total number of cases in a year) of individuals with either SED or SMI in their applications for block grant funds.

As part of the process of implementing this new block grant, definitions of the terms ''children with a serious emotional disturbance'' and ''adults with a serious mental illness'' were announced on May 20, 1993, in **Federal Register** Notice, Volume 58, No. 96, p. 29422. Subsequently, a group of technical experts was convened by CMHS to develop an estimation methodology to ''operationalize'' the key concepts in the definition of children with SED. A similar group prepared an estimation methodology for adults with a SMI (March 28, 1997, **Federal Register** Notice, Volume 62, No. 60 p.14928).

Summary of Comments

This document reflects a thorough review and analysis of comments received in response to an earlier notice published in the **Federal Register**, on October 6, 1997. Ten letters expressing either support or concern regarding the proposed methodology were received by the close of the public comment period. Those expressing support praised the effort of the CMHS team of technical experts to develop reliable State estimates for the number of children with SED. Comments expressing concern generally noted limitations similar to those identified by the team of technical experts in the original October 6, 1997, **Federal Register** notice. These limitations included the exclusion of children from birth to age 8 and the exclusion of variables such as ethnicity and geographical location. Additionally, concerns were raised about whether the proposed methodology represented prevalence rates more precisely than State surveys or local data collection efforts.

Before addressing the comments, CMHS extends appreciation to representatives from Atlantic County, New Jersey, and the University of Texas Medical Branch at Galveston for directing attention to errors made in Table 3—1995 Estimates of Children and Adolescents with SED by State. The New Jersey upper limit for less-impaired children should read 102,594, and the Utah upper limit estimate should read 38,399. These corrections to Table 3 have been made and will be reflected in all subsequent publications.

Purpose of the Methodology

Although several comments indicated satisfaction with the estimation methodology, several others requested that CMHS clarify appropriate use of the methodology. In response, CMHS emphasizes that the methodology for children and adolescents with SED was developed specifically for States to use in the areas of planning and program development. Since it is obvious that resources for this population of children are inadequate in relation to need, States should continue to set priorities to assure the most cost-effective use of all available resources. Inclusion or exclusion of any individual based on this methodology is not intended to either confer or deny eligibility for any other service or benefit at the Federal, State, or local level.

Estimation Methods

Some comments suggested that surveys and other State-specific or local data would provide more precise estimations than the proposed methodology. CMHS understands this concern. However, a group of technical experts established by CMHS determined that the most valid method to estimate the prevalence of SED was to examine findings from extant community epidemiological studies that used a structured diagnostic interview connected to the DSM–III or DMS–III–R system. The group of technical experts thoroughly searched for studies that met this criteria and incorporated findings from all of the studies in its report. CMHS recognizes the value of local or statewide surveys but continues to support the view that the most valid estimates can be derived from community epidemiological studies that have used a structured diagnostic interview. CMHS will support the use of State data if they are based on community epidemiological studies that include a standardized diagnostic interview that is linked with the DSM system and that also includes a measurement of functional impairment.

Concerns were also raised that the singular use of poverty as an adjustment to prevalence rates was based on convenience. This is not the case and the October 6, 1997, **Federal Register** Notice summarizes the fastidious efforts taken to examine other potential variables. For each of the other variables considered, either insufficient evidence existed to determine if an adjustment should be made (e.g., for variables such as race and ethnic background, and population density) or the available evidence suggested that adjustment should not be made (i.e., gender). The findings from these efforts indicated that the prevalence of SED is greater in children from low socio-economic backgrounds than in children from middle-class or upper-class backgrounds. As a result, the decision was made to include percent-in-poverty as an adjustment factor. While the data were clear about an overall relationship, in the absence of any national studies, the quantitative adjustment that should be made could not be determined with precision. It therefore was decided that since the report could offer only general estimates of prevalence, given the shortcomings of the available data, the simplest and perhaps clearest way to adjust for percent-in-poverty would be to divide the States into groups based on the percent-in-poverty. Although this ''grouping'' method may potentially exaggerate the differences between States that fall in different categories, the percent-in-poverty measures differ in a relatively minor way. Because the estimates are not to be used to determine funding levels, the decision was made to use this grouping method despite minor problems. It is hoped that additional research will permit more precise estimations in the future.

With regard to estimation methods, concerns were also raised that the selection of poverty as the only variable to ''correct'' the estimated prevalence of SED would produce data that underestimated the State prevalence rates of SED. Several States emphasized that additional factors, including geographical data (urban/rural), would provide more representative data. CMHS recognizes the importance of this data. However, presently, the data in this area is not precise enough to draw estimates; in the absence of a national study, CMHS chose to utilize and analyze the most precise data available. In this instance, percent-in-poverty rates proved to be the most precise data available. As new data become available, these issues will be revisited.

One comment raised specific questions about the comparability of the prevalence estimates for children with SED with estimates from other studies. For example, Knitzer, in ''At the Schoolhouse Door,'' estimates that 3 to 5 percent of children are ''judged to be seriously emotionally disturbed'' (p. xii). However, this book was published in 1990, before CMHS developed the definition of SED on which the present estimate is based and before the results of most of the studies included in the present report were available. Similarly, the 1969 Joint Commission on the Mental Health of Children indicates that 2 to 3 percent suffered from severe disorders. The present report is based not only on more recent data but also on new instruments and a revised diagnostic system.

Finally, concerns were raised that prevalence estimates for children/adolescent with SED in individual States are not uniformly consistent with estimates for adults with SMI published by CMHS. In comparing data for children and adults, it should be

remembered that the data for children cover a restricted period of nine years (from ages nine through 17) while the adult estimates are for the adult lifetime, beginning at age 18 and over. Therefore, it is not surprising that within the same State estimates for children may be lower or higher than adults. Further, the group of technical experts that developed estimates for SMI found substantially higher prevalence rates in young adults than in older adults. Consequently, States with a high percentage of elderly will have lower overall prevalence rates of SMI than will States with a high percentage of young adults. When comparing adult prevalence rates with those for children, it is important to remember that the children's data are based on a relatively short developmental stage in relation to the adult rates.

Exclusion of Children Age Birth to 8

Several comments acknowledged the paucity of research on children from birth to 8 years and inquired about future research efforts by CMHS to address this population. CMHS acknowledges the need to develop estimation methodology for this very important population of young children. Current plans for developing this methodology include an updated literature review of prevalence data for children with a SED in the birth to 8 age group. CMHS will make these data available when obtained.

Exclusion of Puerto Rico

It was brought to the attention of CMHS that there was significant interest in obtaining prevalence estimates for children with SED in Puerto Rico. Estimates of children with SED, published on Monday, October 6, 1997, in **Federal Register**, Notice Volume 62, No 193, p. 52139, were based on 1995 U.S. Census Bureau population and poverty rate data. These Census Bureau estimates are not available for Puerto Rico and other U.S. territories. CMHS responds to these comments by obtaining SED estimates for Puerto Rico derived from 1990 census data (the most recent year for which data are available).

According to the Census Bureau, the poverty rate for Puerto Rico in 1990 was 66.8 percent for persons under 18 years. Using the steps outlined on page 52141 of the above **Federal Register** Notice, Puerto Rico with a poverty rate of 66.8 percent will be included in group C (the group with poverty rates in excess of 22 percent). At a level of functioning of 50 (LOF=50), the number of children and adolescents with SED is estimated to be between 7–9 percent of youth 9–17 years of age. At a level of functioning of 60 (LOF=60), the number of children and adolescents with SED is estimated to be between 11–13 percent of youth 9–17 years of age.

TABLE 1.—ESTIMATES OF CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE; STATE ESTIMATES ALGORITHMS

Territory	Number of youth 9–17	Percent in poverty	LOF*=50		LOF*=60	
			Lower limit	Upper limit	Lower limit	Upper limit
Puerto Rico	602,309	66.8	42,162	54,208	66,254	78,300

*LOF=Level of functioning from Children's Global Assessment Scale.

Exclusion of Substance Use Disorders

The decision to exclude substance use disorders from this estimation methodology was addressed in the 1993 **Federal Register** Notice that provided a national definition of SED. Because substance use disorders are not included in the definition of serious emotional disorder, they are not included in the current estimation methodology. Please see the **Federal Register** Notice (1993, 58(96), p. 29424) for a more detailed explanation.

Instrumentation

CMHS stresses that the methodology is based on the Children's Global Assessment Scale (CGAS) because the CGAS was the most commonly used instrument found in the community-based epidemiology literature received by the group of technical experts. When other instruments were used, the findings were taken into consideration. CMHS recognizes that a number of States use the Children's Adolescent Functional Assessment Scale-Mini-Scale and, consequently, does not discourage the use of this instrument.

Definition of Serious Emotional Disturbance

Some States expressed concern that the definition of SED used to estimate prevalence may result in an over-estimate of prevalence by counting children who had a diagnosis and functional impairment over a 2-year period rather than a 1-year period.

The definition used to estimate prevalence is ''total number of cases in a year.'' None of the studies cited in the report gathered prevalence information of a duration of greater than a year. In fact, most of the studies used to formulate the prevalence estimates utilized the Diagnostic Interview Schedule for Children, which derives prevalence information for a 6-month time period. Therefore, not only does the definition ensure against an over estimate of prevalence but also there is a possibility of a slight under estimate, based on the methods used.

Estimation Procedures

The following steps were taken to adjust for differences in State socio-economic circumstances. The 1995 State-by-State estimates of children and adolescents with SED are provided in Table 3.

Step 1

States were sorted by poverty rates (1995), in ascending order. Using this sort order, States were initially classified into three groups of equal proportions, i.e., the first 17 States were put into Group A; the next 17 States, into Group B; the remaining 17 States, into Group C. However, in reviewing the results, we noted that observations 17 and 18 differed by .01 percent. Observation number 18 was included in group A. For this reason, Group A has 18 cases, Group B has 16 cases, and Group C has 17 cases. Group A is the lowest percentage of children in poverty; Group B represents a mid-point; and Group C includes the highest percentage of children in poverty.

Step 2

At a level of functioning of 50 (LOF=50), the number of children and adolescents with SED is calculated to be between 5–7 percent of the number of youth between 9–17 years for Group A. For Group B, the estimate is between 6–8 percent of the number of youth 9–17 years. The estimated SED population for

Group C is calculated to be between 7–9 percent of the number of youth 9–17 years.

Step 3

At a level of functioning of 60 (LOF=60), the number of children and adolescents with SED is calculated to be between 9–11 percent of the number of youth 9–17 years for Group A. For Group B, the estimate is between 10–12 percent of the number of youth 9–17 years. The estimated SED population for Group C is calculated to be between 11–13 percent of the number of youth 9–17 years.

TABLE 2.—1995 ESTIMATES OF CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE; STATE ESTIMATES ALGORITHMS

States	Estimated population			
	LOF*=50		LOF*=60	
	Lower limit	Upper limit	Lower limit	Upper limit
Group A Lowest percent in poverty	5%	7%	9%	11%
Group B Medium percent in poverty	6%	8%	10%	12%
Group C Highest percent in poverty	7%	9%	11%	13%

*LOF=Level of functioning from the Children's Global Assessment Scale.

TABLE 3.—1995 ESTIMATES OF CHILDREN & ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE BY STATE

	State	Number of youth 9–17	Percent in poverty	LOF*=50		LOF*=60	
				Lower limit	Upper limit	Lower limit	Upper limit
	Total	33,706,204	.....	2,118,269	2,792,391	3,466,516	4,140,636
1	New Hampshire	147,695	4.07	7,385	10,339	13,293	16,246
2	Alaska	90,955	8.96	4,548	6,367	8,186	10,005
3	New Jersey	932,671	9.60	46,634	65,287	83,940	102,594
4	Utah	349,086	9.76	17,454	24,436	31,418	38,399
5	Minnesota	643,892	11.30	32,195	45,072	57,950	70,828
6	Colorado	491,930	11.34	24,597	34,435	44,274	54,112
7	Nebraska	231,037	11.62	11,552	16,173	20,793	25,414
8	Missouri	709,439	11.74	35,472	49,661	63,850	78,038
9	Kansas	354,722	12.55	17,736	24,831	31,925	39,019
10	Wisconsin	706,004	12.56	35,300	49,420	63,540	77,660
11	Hawaii	143,901	13.97	7,195	10,073	12,951	15,829
12	North Dakota	91,443	14.13	4,572	6,401	8,230	10,059
13	Virginia	790,359	14.38	39,518	55,325	71,132	86,939
14	Nevada	186,695	14.41	9,335	13,069	16,803	20,536
15	Indiana	758,633	15.24	37,932	53,104	68,277	83,450
16	Rhode Island	115,176	15.36	5,759	8,062	10,366	12,669
17	Delaware	85,396	15.56	4,270	5,978	7,686	9,394
18	Maine	160,434	15.57	8,022	11,230	14,439	17,648
19	Vermont	76,500	15.79	4,590	6,120	7,650	9,180
20	Maryland	608,209	15.80	36,493	48,657	60,821	72,985
21	Wyoming	75,106	16.21	4,506	6,008	7,511	9,013
22	Georgia	942,161	16.30	56,530	75,373	94,216	113,059
23	Massachusetts	680,101	17.12	40,806	54,408	68,010	81,612
24	Iowa	385,583	17.39	23,135	30,847	38,558	46,270
25	Washington	714,567	17.81	42,874	57,165	71,457	85,748
26	Connecticut	378,473	18.03	22,708	30,278	37,847	45,417
27	Pennsylvania	1,462,731	18.07	87,764	117,018	146,273	175,528
28	Oregon	411,543	18.22	24,693	32,923	41,154	49,385
29	Michigan	1,275,452	18.36	76,527	102,036	127,545	153,054
30	Ohio	1,451,220	19.33	87,073	116,098	145,122	174,146
31	Idaho	183,829	20.57	11,030	14,706	18,383	22,059
32	South Dakota	108,855	20.74	6,531	8,708	10,886	13,063
33	North Carolina	879,091	21.06	52,745	70,327	87,909	105,491
34	Kentucky	504,373	21.25	30,262	40,350	50,437	60,525
35	Illinois	1,517,182	22.14	106,203	136,546	166,890	197,234
36	Tennessee	658,573	22.23	46,100	59,272	72,443	85,614
37	Montana	126,834	22.39	8,878	11,415	13,952	16,488
38	Arkansas	337,718	22.44	23,640	30,395	37,149	43,903
39	Texas	2,623,654	24.53	183,656	236,129	288,602	341,075
40	California	3,968,950	24.97	277,827	357,206	436,585	515,964
41	Oklahoma	457,496	24.98	32,025	41,175	50,325	59,474
42	Arizona	542,019	25.31	37,941	48,782	59,622	70,462
43	Florida	1,623,697	25.50	113,659	146,133	178,607	211,081
44	New York	2,141,435	25.51	149,900	192,729	235,558	278,387
45	West Virginia	231,390	26.93	16,197	20,825	25,453	30,081
46	Alabama	547,671	27.50	38,337	49,290	60,244	71,197
47	Louisiana	639,158	29.69	44,741	57,524	70,307	83,091

TABLE 3.—1995 ESTIMATES OF CHILDREN & ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE BY STATE—Continued

State	Number of youth 9–17	Percent in poverty	LOF*=50		LOF*=60	
			Lower limit	Upper limit	Lower limit	Upper limit
48 South Carolina	470,875	32.11	32,961	42,379	51,796	61,214
49 Washington, DC	48,365	35.33	3,386	4,353	5,320	6,287
50 New Mexico	251,231	36.59	17,586	22,611	27,635	32,660
51 Mississippi	392,694	37.03	27,489	35,342	43,196	51,050

Dated: June 29, 1998.

Joseph Faha,

Director, Legislation & External Affairs.

[FR Doc. 98–19039 Filed 7–16–98; 8:45 am]

BILLING CODE 4160–20–U

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4341–N–19]

Federal Property Suitable as Facilities to Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

FOR FURTHER INFORMATION CONTACT: Mark Johnston, room 7256, Department of Housing and Urban Development, 451 Seventh Street SW, Washington, DC 20410; telephone (202) 708–1226: TTY number for the hearing- and speech-impaired (202) 708–2565 (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with 24 CFR part 581 and section 501 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11411), as amended, HUD is publishing this Notice to identify Federal buildings and other real property that HUD has reviewed for suitability for use to assist the homeless. The properties were reviewed using information provided to HUD by Federal landholding agencies regarding unutilized and underutilized buildings and real property controlled by such agencies or by GSA regarding its inventory of excess or surplus Federal property. This Notice is also published in order to comply with the December 15, 1988 Court Order in *National Coalition for the Homeless* v. *Veterans Administration,* No. 88–2503–OG (D.D.C.).

Properties reviewed are listed in this Notice according to the following categories: Suitable/available, suitable/unavailable, suitable/to be excess, and unsuitable. The properties listed in the three suitable categories have been reviewed by the landholding agencies, and each agency has transmitted to HUD: (1) Its intention to make the property available for use to assist the homeless, (2) its intention to declare the property excess to the agency's needs, or (3) a statement of the reasons that the property cannot be declared excess or made available for use as facilities to assist the homeless.

Properties listed as suitable/available will be available exclusively for homeless use for a period of 60 days from the date of this Notice. Homeless assistance providers interested in any such property should send a written expression of interest to HHS, addressed to Brian Rooney, Division of Property Management, Program Support Center, HHS, room 5B–41, 5600 Fishers Lane, Rockville, MD 20857; (301) 443–2265. (This is not a toll-free number.) HHS will mail to the interested provider an application packet, which will include instructions for completing the application. In order to maximize the opportunity to utilize a suitable property, providers should submit their written expressions of interest as soon as possible. For complete details concerning the processing of applications, the reader is encouraged to refer to the interim rule governing this program, 24 CFR part 581.

For properties listed as suitable/to be excess, that property may, if subsequently accepted as excess by GSA, made available for use by the homeless in accordance with applicable law, subject to screening for other Federal use. At the appropriate time, HUD will publish the property in a Notice showing it as either suitable/available or suitable/unavailable.

For properties listed as suitable/unavailable, the landholding agency has decided that the property cannot be declared excess or made available for use to assist the homeless, and the property will not be available.

Properties listed as unsuitable will not be made available for any other purpose for 20 days from the date of this Notice. Homeless assistance providers interested in a review by HUD of the determination of unsuitability should call the toll free information line at 1–800–927–7588 for detailed instructions or write a letter to Mark Johnston at the address listed at the beginning of this Notice. Included in the request for review should be the property address (including zip code), the date of publication in the **Federal Register,** the landholding agency, and the property number.

For more information regarding particular properties identified in this Notice (*i.e.*, acreage, floor plan, existing sanitary facilities, exact street address), providers should contact the appropriate landholding agencies at the following addresses: INTERIOR: Ms. Lola D. Knight, Department of Interior, 1849 C Street, NW, Mail Stop 5512–MIB, Washington, DC 20240; (202) 208–4080; GSA: Mr. Brian K. Polly, Assistant Commissioner, General Services Administration, Office of Property Disposal, 18th and F Streets, NW, Washington, DC 20405; (202) 501–2059; NAVY: Mr. Charles C. Cocks, Department of the Navy, Director, Real Estate Policy Division, Naval Facilities Engineering Command, Code 241A, 200 Stovall Street, Alexandria, VA 22332–2300; (703) 325–6342; TRANSPORTATION: Mr. Rugene Spruill, Principal, Space Management, SVC–140, Transportation Administrative Service Center, Department of Transportation, 400 7th Street, SW, Room 2310, Washington, DC 20590; (202) 366–4246; (These are not toll-free numbers).