designed to offset the expenses associated with operating approved graduate medical residency training programs and indirect payments are designed to compensate hospitals for expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.

The CHGME Payment Program was reauthorized for a period of five years in October 2006 by Public Law 109–307. The reauthorizing legislation requires that children's hospitals participating and receiving funds from the CHGME Payment Program provide information about their residency training programs in an annual report that will be an addendum to the hospitals' annual applications for funds. Specifically, data are required to be collected on: (1) The types of training programs that the hospital provided for residents such as general pediatrics, internal medicine/pediatrics, and pediatric subspecialties including both American Board of Pediatrics certified medical subspecialties and non-medical subspecialties approved by other medical certification boards; (2) the number of training positions for residents, the number of such positions recruited to fill, and the number of positions filled; (3) the types of training that the hospital provided for residents related to the health care needs of difference populations such as children who are underserved for reasons of family income or geographic location, including rural and urban areas; (4) changes in residency training the hospital made during an academic year, including changes in curricula, training experiences, and types of training programs, and benefits that have resulted from such changes and changes for purposed of training residents in the measurement and improvement and the quality and safety of patient care; and (5) the numbers of residents (disaggregated by specialty and subspecialty) who completed training in the academic year and provide care within the borders of the service area of the hospital or within the borders of the State in which the children's hospital is located. For purposes of the annual report data collection, ''residents'' are those who are (1) in full-time equivalent resident training positions in any training program sponsored by the hospital; or (2) in a training program sponsored by an entity other than the hospital who spend more than 75 percent of their time training at the hospital.

The annual report data collection instruments consist of Excel workbooks with several pages (worksheets) each. These data collection instruments for the annual report were pre-tested by nine participating CHGME Payment Program hospitals. Each hospital provided an estimate of the number of hours required to complete each part of the annual report. Following the pre-test, the data collection instruments were significantly reduced by collapsing certain categories, shifting several questions from the individual GME training program level to the hospital level instrument, and by omitting several questions. As a result, the estimated burden to each respondent was significantly reduced.

The estimated annual burden is as follows:

Form name	Number of respondents	Responses per respondent	Total number of responses	Hours per response	Total burden hours
Screening Instrument	57	1	57	10.0	570.0
Annual Report, Hospital and Program-Level Information	57	1	57	74.8	4263.6
Total	57		57	84.8	4833.6

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by e-mail to *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence to the ''attention of the desk officer for HRSA.''

Dated: September 14, 2007.

Alexandra Huttinger,

Acting Director, Division of Policy Review and Coordination.

[FR Doc. E7–18561 Filed 9–19–07; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Notice of Availability of Final Policy Guidance

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Final Agency Guidance and Response to Public Comments.

SUMMARY: The Health Resources and Services Administration (HRSA) is publishing a final Agency Guidance (''Policy Information Notice'' (PIN) 2007–16) to describe and clarify the circumstances under which Federal Tort Claims Act (FTCA)—deemed Health Center Program grantees are covered under the FTCA as they respond to emergencies. The PIN, ''Federal Tort Claims Act Coverage for Health Center Program Grantees Responding to Emergencies,'' and the Agency's ''Response to Public Comments'' are available on the Internet at *http://bphc.hrsa.gov/policy/pin0716.*

DATES: The effective date of this final Agency guidance is August 22, 2007.

BACKGROUND: HRSA administers the Health Center Program, which supports more than 3,800 health care delivery sites, including community health centers, migrant health centers, health care for the homeless centers, and public housing primary care centers. Health centers serve clients that are primarily low-income and minorities, and deliver comprehensive, culturally competent, quality primary health care services to patients regardless of their ability to pay. Charges for health care services are set according to income.

On March 15, 2007, HRSA made the draft PIN, ''Federal Tort Claims Act Coverage for Health Center Program Grantees Responding to Emergencies,'' available for public comment on HRSA's Web site. Comments were due to HRSA by May 31, 2007.

Comments were received from 14 organizations and/or individuals. After review and careful consideration of all comments received, HRSA has amended the PIN to incorporate certain recommendations from the public. The final PIN reflects these changes.

In addition to making the final PIN available on HRSA's Web site, HRSA is also posting the Agency's ''Response to Public Comments.'' The purpose of that document is to summarize the major comments received and describe the Agency's response, including any corresponding changes made to the PIN. Where comments did not result in a

revision to the PIN, explanations are provided.

FOR FURTHER INFORMATION CONTACT: For questions regarding this notice, please contact the Office of Policy and Program Development, Bureau of Primary Health Care, HRSA, at 301–594–4300.

Dated: September 14, 2007.

Elizabeth M. Duke,

Administrator.

[FR Doc. E7–18562 Filed 9–19–07; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Notice of Availability of Final Policy Guidance

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Final Agency Guidance and Response to Public Comments.

DATES: The effective date of this final Agency guidance is August 22, 2007.

SUMMARY: The Health Resources and Services Administration (HRSA) is publishing a final Agency Guidance (''Policy Information Notice'' (PIN) 2007–15) to provide guidance on emergency management expectations for health centers to assist them in planning and preparing for future emergencies through the development and maintenance of an effective and appropriate emergency management strategy. The PIN, ''Health Center Emergency Management Program Expectations,'' and the Agency's ''Response to Public Comments'' are available on the Internet at *http://bphc.hrsa.gov/policy/pin0715.*

Background: HRSA administers the Health Center Program, which supports more than 3,800 health care delivery sites, including community health centers, migrant health centers, health care for the homeless centers, and public housing primary care centers. Health centers serve clients that are primarily low-income and minorities, and deliver comprehensive, culturally competent, quality primary health care services to patients regardless of their ability to pay. Charges for health care services are set according to income.

On February 27, 2007, HRSA made the draft PIN available for public comment on HRSA's Web site. The purpose of the PIN was to provide guidance on emergency management expectations for health centers to assist them in planning and preparing for future emergencies. Comments were due to HRSA by April 13, 2007.

Comments were received from 31 organizations and/or individuals. After review and careful consideration of all comments received, HRSA amended the PIN to incorporate certain recommendations from the public. The final PIN reflects these changes.

In addition to making the final PIN available on HRSA's Web site, HRSA is also posting the Agency's ''Response to Public Comments.'' The purpose of the document is to summarize the major comments received and describe the Agency's response, including any corresponding changes made to the PIN. Where comments did not result in a revision to the PIN, explanations are provided.

FOR FURTHER INFORMATION CONTACT: Please contact the Office of Policy and Program Development at (301) 594–4300 for any questions regarding this PIN.

Dated: September 14, 2007.

Elizabeth M. Duke,

Administrator.

[FR Doc. E7–18560 Filed 9–19–07; 8:45 am]

BILLING CODE 4165–15–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: Independent Evaluation of the Substance Abuse Prevention and Treatment Block Grant Program—NEW

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), Division of State and Community Assistance administers the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) in collaboration with the Center for Substance Abuse Prevention (CSAP), Division of State Programs. The Substance Abuse Prevention and Treatment Block Grant is funded by Congress to provide monies to States, Territories, and one Native American Tribe for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and other allowable activities. The SAPT BG constitutes approximately 40 percent of all States budgets for substance abuse prevention and treatment services and activities, and is the primary Federal source of funding. States have flexibility in determining how funds should be allocated, but there are specific set-aside and maintenance of effort requirements that must be met in order to receive funding. These requirements, introduced by both the ADAMHA Reorganization Act of 1992 and the Children's Health Act of 2000, are listed below:

TABLE 1.—SAPT BG SET-ASIDE PROVISIONS [a]

Category	Set-aside provision
Prevention and treatment activities regarding alcohol.	Not less than 35 percent of SAPT BG funding*.
Prevention and treatment activities regarding other drugs.	Not less than 35 percent of SAPT BG funding*.
Primary prevention programs	Not less than 20 percent of SAPT BG funding.
Pregnant women and women with dependent children.	Not less than amount equal to expenditure in FY 1994.
Tuberculosis services	No set amount but services must be provided to receive SAPT BG funds.
HIV services [b]	No more than 5 percent increase over State allotment for HIV services in FY 1991.