oral conditions, as well as leading to nicotine addiction and dependence. Furthermore, SLT use is not a safe substitute for cigarette smoking. Adolescents who use smokeless tobacco are more likely to become cigarette smokers.

The Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH), has primary responsibility for the Department of Health and Human Services (HHS) smoking and health program. HHS's overall goal is to reduce death and disability resulting from the use of smokeless tobacco products and other forms of tobacco through programs of information, education and research.

The Comprehensive Smokeless Tobacco Health Education Act of 1986 (CSTHEA, 15 U.S.C. 4401 *et seq.,* Pub. L. 99–252) requires each person who manufactures, packages, or imports smokeless tobacco products to provide the Secretary of Health and Human Services (HHS) with a list of ingredients added to tobacco in the manufacture of smokeless tobacco products. CSTHEA further requires submission of the quantity of nicotine contained in each smokeless tobacco product. Finally, the legislation authorizes HHS to undertake research, and to report to Congress (as deemed appropriate) discussing the health effects of these ingredients.

HHS has delegated responsibility for implementing the required information collection to CDC's Office on Smoking and Health. Respondents are not required to submit specific forms; however, they are required to meet reporting guidelines and to submit the ingredient report by chemical name and Chemical Abstract Service (CAS) Registration Number, consistent with accepted reporting practices for other companies that are required to report ingredients added to other consumer products. Typically, respondents submit a summary report to CDC with the ingredient information for multiple products, or a statement that there are no changes to their previously submitted ingredient report. Respondents may submit the required information to CDC through a designated representative.

Ingredient reports for new SLT products are due at the time of first importation. Thereafter, ingredient reports are due annually on March 31. Information is submitted to OSH by mailing a written report on the respondent's letterhead, by CD, three-inch floppy disk, or thumb drive. Electronic mail submissions are not accepted. Upon receipt and verification of the annual nicotine and ingredient report, OSH issues a Certificate of Compliance to the respondent.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Smokeless Tobacco Manufacturers, Packagers, and Importers.	SLT Nicotine and Ingredient and Report.	11	1	1,713	18,843

Dated: November 9, 2010.

Carol E. Walker,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2010–28786 Filed 11–15–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Office of Community Services (OCS) Community Economic Development (CED) and Job Opportunities for Low-Income Individuals (JOLI) Standard Reporting Format.

OMB No.: New Collection.

Description: The Office of Community Services (OCS) is collecting key information about projects funded through the Community Economic Development (CED) and Job Opportunities for Low-Income Individuals (JOLI) programs. The legislative requirement for these two programs is in Title IV of the Community Opportunities, Accountability and Training and Educational Services Act (COATS Human Services Reauthorization Act) of October 27, 1998, Public Law 105–285, section 680(b) as amended. The Performance Progress Report (PPR) is a new proposed reporting format that will collect information concerning the outcomes and management of CED and JOLI projects. OCS will use the data to critically review the overall design and effectiveness of each program.

The PPR will be administered to all active grantees of the CED and JOLI programs. Grantees will be required to use this reporting tool for their semiannual reports. The majority of the questions in this tool were adapted from a previously approved questionnaire, Office of Management and Budget (OMB) Control Number: 0970–0317. Questions were also adapted to the OMB-approved reporting format of the PPR, specifically forms SF–PPR, SF–PPR–A, SF–PPR–B, and SF–PPR–E. Additional changes were made to improve the clarity and quality of the data and to eliminate unnecessary questions. The PPR will replace both the annual questionnaire and the current semi-annual reporting format, which will result in an overall reduction in burden for the grantees while significantly improving the quality of the data collected by OCS.

Respondents: Current CED and JOLI grantees.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Questionnaire for current OCS–JOLI grantees	40	2	1.50	120
Questionnaire for current OCS–CED grantees	170	2	1.50	510

Estimated Total Annual Burden Hours: 630.

Additional Information:

Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, *Attn:* ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. *E-mail address: infocollection@acf.hhs.gov.*

OMB Comment:

OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following:

Office of Management and Budget, Paperwork Reduction Project, *Fax:* 202–395–7285, *E-mail: OIRA_SUBMISSION@OMB.EOP.GOV, Attn:* Desk Officer for the Administration for Children and Families.

Dated: November 10, 2010.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–28855 Filed 11–15–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Development of Health Risk Assessment Guidance

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Request for Information.

SUMMARY: The Centers for Disease Control and Prevention (CDC) located within the Department of Health and Human Services (HHS) is seeking public comment on the development of guidance concerning Health Risk Assessment (HRAs). Section 4103 of the Affordable Care Act (ACA) (Pub. L. 111–148) requires that a health risk assessment be included in the annual wellness visit benefit authorized for Medicare beneficiaries under the ACA. CDC is collaborating with the Centers for Medicare and Medicaid Services (CMS), also located within HHS, in the development of guidance for this type of assessment. This guidance is also intended to be useful for HRAs conducted in other patient populations such as privately insured populations, including those persons covered by employer healthcare plans. Comments received from this request for information will be used to inform the HRA guidance development process.

DATES: Written comments must be received on or before January 3, 2011. Comments received after January 3, 2011 will be considered to the extent possible.

ADDRESSES: You may submit written comments to the following address: Office of Prevention through Healthcare, Office of the Associate Director for Policy, Centers for Disease Control and Prevention, 1600 Clifton Road, NE., Mailstop D–28, Atlanta, Georgia, 30333, ATTN: Health Risk Assessment Guidance.

You may also submit written comments via e-mail to: *OPTH@cdc.gov.* Please use "Health Risk Assessment Guidance" for the subject line.

Submitted comments will be available for public review from Monday through Friday, except for legal holidays, from 9 a.m. until 5 p.m. Eastern Standard Time, at 1600 Clifton Road NE., Atlanta, Georgia 30333. Please call ahead to 1–404–639–0210 and ask for a representative in the Office of Prevention through Healthcare to schedule your visit. Comments will also be available for viewing at the following Internet address: *http://www.cdc.gov/policy/opth/.*

CDC will make all comments it receives available to the public without change, including personal information you may provide, which includes the name of the person submitting the comment or signing the comment on behalf of an organization, business, or any such entity. If anyone does not wish to have this information published, then that information should not be included when submitting the comment.

FOR FURTHER INFORMATION CONTACT: Paula Staley, Office of Prevention through Healthcare, Associate Director for Policy, Centers for Disease Control and Prevention, 1600 Clifton Road, NE., Mailstop D–28, Atlanta, Georgia, 30333, telephone: (404) 639–0210.

SUPPLEMENTARY INFORMATION:

Section 4103 of the Affordable Care Act (ACA) requires that a health risk assessment be included in the annual wellness visit benefit authorized for Medicare beneficiaries under the ACA. CDC is collaborating with CMS to develop guidance for this type of assessment. This guidance is also intended to be useful for HRAs conducted in other patient populations such as privately insured populations, including those persons covered by employer healthcare plans.

Currently there is considerable variation in available HRAs, with the majority of assessments created to support employer-based health and wellness programs. Several instruments have been created for use in research and are not available in the marketplace; and the scientific rigor of HRA tools is not always evident. Therefore, the development of HRA guidance is essential for effective implementation of this part of the Medicare wellness visit and to support broader HRA use within primary care.

Although comments on any aspect of the guidance development process will be accepted, comments are especially solicited about these areas of emphasis:

Content and Design

- Risk assessment domains—What are generic elements of any HRA and what elements must be tailored to specific populations, particularly those stratified by age?
- How should literacy and other cultural appropriateness factors be factored into the design?
- How should the HRA instrument support shared decision-making by provider and patient?

Mode of Administration

- How will individuals access the HRA (*e.g.,* via kiosk or some other means in the physician's office, Internet, mail-in paper form, other non-traditional healthcare locations, such as, kiosk in a pharmacy)?
- What are the cultural appropriateness factors in patient HRA access?

Primary Care Office Capacity

- What primary care office capacity (personnel, Information Technology (IT), etc) is required to utilize HRA data effectively in support of personalized prevention planning?
- Are training and technical assistance necessary for effective practice utilization of an HRA? What entity should provide this technical assistance?
- What are potential or demonstrated community care transition linkages—follow-up outside the office by other providers—that help patients and providers manage priority risks identified by the HRA?
- What is the current practice of HRA in medical practices of various sizes, particularly those with five or fewer physicians?