initial Report to Congress, including new developments, challenges, opportunities, and solutions to better recognize and support family caregivers along with recommendations for priority actions to update, improve, and keep current the National Family Caregiving Strategy, as appropriate.

The Advisory Council will submit an annual report on the development, maintenance, and updating of the National Family Caregiving Strategy. The report will include a description of the implementation of the actions recommended in the initial report, as appropriate. This report will be provided to the Secretary, Congress, and the state agencies responsible for carrying out family caregiver programs.

The Advisory Council, or its individual members, may also be engaged to author/co-author articles and other materials; engage with print and electronic media; and deliver presentations, workshops, webinars and other forms of educational opportunities designed to highlight the Administration's commitment to supporting families and family caregivers.

As needed, and where appropriate, this Advisory Council will coordinate its efforts with those of the Advisory Council to Support Grandparents Raising Grandchildren. Such coordination might include joint meetings, presentations and other activities undertaken in fulfillment of the requirements of the RAISE Act.

The Advisory Council will meet virtually (via Zoom or similar platform), at least three times each year, beginning in September/October 2022. Council meetings will generally be held from 12:30 to 4:30 p.m., Eastern Time. All meetings of the Council will be open to the public and recorded for posting on the ACL website. Advisory Council members will be expected to participate in at least one subcommittee, which will meet, as needed, between Advisory Council meetings to develop and review materials and conduct other activities related to the Advisory Council's mission and purpose.

The completion of all described activities is dependent upon the continued availability of federal funding for the purposes of carrying out the legislation.

Nomination Process: Any person or organization may nominate one or more qualified individuals for membership. Current Advisory Council members whose terms are expiring may also submit a nomination for consideration. Nomination packages must include:

(1) A nomination letter not to exceed one (1) page that provides ALL of the following information:

a. The reason(s) for nominating the individual;

b. The constituency being represented (from the list above; may be more than one);

c. The nominee's particular, relevant experience and/or professional expertise or lived experience;

d. Contact information for the nominee [name, title (if applicable), address, phone, and email address]; and

e. The nominee's resume (not to exceed two (2) pages) if the nomination is based on their professional capacity or qualifications. A resume is optional otherwise.

Nominees will be selected for appointment based on their demonstrated knowledge, qualifications, and professional or personal experience related to the purpose and scope of the Advisory Council.

(2) Members will be appointed for a period not to exceed three years. Members appointed to fill subsequent vacancies will serve for the remainder of the current term of the Advisory Council.

Dated: March 4, 2022.

Alison Barkoff,

Principal Deputy Administrator, Administration for Community Living.

[FR Doc. 2022–05152 Filed 3–10–22; 8:45 am]

BILLING CODE 4154–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

"Low Income Levels" Used for Various Health Professions and Nursing Programs Authorized in Titles III, VII, and VIII of the Public Health Service Act

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: HRSA is updating income levels used to identify a ''low-income family'' for the purpose of determining eligibility for programs that provide health professions and nursing training to individuals from disadvantaged backgrounds. These various programs are authorized in Titles III, VII, and VIII of the Public Health Service Act. HHS periodically publishes in the **Federal Register** low-income levels to be used by institutions receiving grants or cooperative agreement awards to determine eligibility for programs providing training for (1) disadvantaged individuals, (2) individuals from disadvantaged backgrounds, or (3) individuals from low-income families.

SUPPLEMENTARY INFORMATION: Many health professions and nursing grant and cooperative agreement awardees use the low-income levels to determine whether potential program participants are from economically disadvantaged backgrounds and would be eligible to participate in the program, as well as to determine the amount of funding individuals receive. Awards are generally made to accredited schools of medicine, osteopathic medicine, public health, dentistry, veterinary medicine, optometry, pharmacy, allied health, podiatric medicine, nursing, and chiropractic; public or private nonprofit schools which offer graduate programs in behavioral health and mental health practice; and other public or private nonprofit health or educational entities to assist individuals from disadvantaged backgrounds and disadvantaged students to enter and graduate from health professions and nursing schools. Some programs provide for the repayment of health professions or nursing education loans for students from disadvantaged backgrounds and disadvantaged students.

A ''low-income family/household'' for programs included in Titles III, VII, and VIII of the Public Health Service Act is defined as having an annual income that does not exceed 200 percent of HHS's poverty guidelines. A family is a group of two or more individuals related by birth, marriage, or adoption who live together.

Most HRSA programs use the income of a student's parent(s) to compute low income status. However, a ''household'' may potentially be only one person. Other HRSA programs, depending upon the legislative intent of the program, the programmatic purpose related to income level, as well as the age and circumstances of the participant, will apply these low income standards to the individual student to determine eligibility, as long as the individual is not listed as a dependent on the tax form of their parent(s). Each program includes the rationale and methodology for determining low income levels in program funding opportunities or applications.

Low-income levels are adjusted annually based on HHS's poverty guidelines. HHS's poverty guidelines are based on poverty thresholds published by the U.S. Census Bureau, adjusted annually for changes in the Consumer Price Index. The income

figures below have been updated to reflect HHS's 2022 poverty guidelines as published in the **Federal Register** at 87 FR 3315. See *https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines.*

LOW INCOME LEVELS BASED ON THE 2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household *	Income level **
1	$27,180
2	36,620
3	46,060
4	55,500
5	64,940
6	74,380
7	83,820
8	93,260

For families with more than 8 persons, add $9,440 for each additional person.

* Includes only dependents listed on federal income tax forms.

** Adjusted gross income for calendar year 2021.

LOW INCOME LEVELS BASED ON THE 2022 POVERTY GUIDELINES FOR ALASKA

Persons in family/household *	Income level **
1	$33,980
2	45,780
3	57,580
4	69,380
5	81,180
6	92,980
7	104,780
8	116,580

For families with more than 8 persons, add $11,800 for each additional person.

* Includes only dependents listed on federal income tax forms.

** Adjusted gross income for calendar year 2021.

LOW INCOME LEVELS BASED ON THE 2022 POVERTY GUIDELINES FOR HAWAII

Persons in family/household *	Income level **
1	$31,260
2	42,120
3	52,980
4	63,840
5	74,700
6	85,560
7	96,420
8	107,280

For families with more than 8 persons, add $10,860 for each additional person.

* Includes only dependents listed on federal income tax forms.

** Adjusted gross income for calendar year 2021.

Separate poverty guidelines figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period since the U.S. Census Bureau poverty thresholds do not have separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico or other jurisdictions. Puerto Rico and other jurisdictions shall use income guidelines for the 48 Contiguous States and the District of Columbia.

Carole Johnson,

Administrator.

[FR Doc. 2022–05234 Filed 3–10–22; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request Health Center Workforce Survey OMB No. 0906–XXXX–New

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR should be received no later than May 10, 2022.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or by mail to the HRSA Information Collection Clearance Officer, Room 14N136B, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call Samantha Miller, the acting HRSA Information Collection Clearance Officer at (301) 443–9094.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the information collection request title for reference.

Information Collection Request Title: Health Center Workforce Survey OMB No. 0906–XXXX–New.

Abstract: The Health Center Program, authorized by section 330 of the Public Health Service Act, 42 U.S.C. 254b, and administered by HRSA, Bureau of Primary Health Care, supports the provision of community-based preventive and primary health care services to millions of medically underserved and vulnerable people. Health centers employ over 400,000 health care staff (*i.e.,* physicians, medical, dental, mental and behavioral health, vision services, pharmacy, enabling services, quality improvement, and facility and non-clinical support staff.)

Provider and non-provider staff well-being is essential to recruiting and retaining staff, thus supporting access to quality health care and services through the Health Center Program. HRSA has created a nationwide Health Center Workforce Survey to identify and address challenges related to provider and staff well-being. The survey will be administered to all full-time and part-time health center staff in the fall of 2022 to identify conditions and circumstances that affect staff well-being at HRSA-funded health centers, including the scope and nature of workforce well-being, job satisfaction, and burnout. This information can inform efforts to improve workforce well-being and maintain high-quality patient care.

The Health Center Workforce Survey aims to collect and analyze data from no less than 85 percent of health center staff. HRSA will utilize stakeholder engagement strategies to support survey completion targets. The HRSA contractor will request email addresses for all health center staff from health center leadership. Using the email addresses provided, the contractor will administer the online survey to ensure data quality and respondent confidentiality. Participation in the Health Center Workforce Survey is voluntary for all health center staff. The contractor will analyze the responses and provide analytic reports. HRSA will disseminate the summary level data for public use, including preparing preliminary findings and analytic reports.

Need and Proposed Use of the Information: Health care workforce burnout has been a challenge even prior to COVID–19 and other recent public health crises. Clinicians and health care staff have reported experiencing alarming rates of burnout, characterized as a high degree of emotional exhaustion, depersonalization, and a