and at the WWAMI (Washington, Wyoming, Alaska, Montana, & Idaho) Rural Health Research Center's Web site, *http://depts.washington.edu/uwruca/.*

In the past, ORHP has issued a list of eligible, rural ZIP codes in Metropolitan counties based on the RUCAs rather than eligible census tracts due to potential applicants for Rural Health grants being able to easily ascertain whether they lived in an eligible ZIP code area. However, with the advent of the World Wide Web, applicants are now able to easily access information about census tracts, and to identify the tract identifying number of any address—(*http://www.ffiec.gov/geocode/default.htm*). Further information on the ZIP code approximation of the census tract-based RUCA codes is available at *http://depts.washington.edu/uwruca/approx.html.*

HRSA believes that the use of RUCAs allows more accurate targeting of resources intended for the rural population. Both ORHP and CMS have been using RUCAs for several years to determine programmatic eligibility for rural areas inside of Metropolitan counties.

ORHP currently considers all census tracts with RUCA codes 4–10 to be rural. While use of the RUCA codes has allowed identification of rural census tracts in Metropolitan counties, among the more than 60,000 tracts in the U.S. there are some that are extremely large and where use of RUCA codes alone fails to account for distance to services and sparse population. In response to these concerns, ORHP has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people.

ORHP will continue to seek refinements in the use of RUCAs. This may include further data on travel times so that areas with heavy commuting to urbanized areas, but which are too distant from the urbanized area for the residents to be able to easily access health care services, can also be designated as rural.

HRSA is now seeking public comments on:

1. The use of census tract RUCA codes to determine eligibility rather than RUCA codes which have been cross-walked to ZIP code areas,

2. The possible use of RUCA sub-codes, to more accurately identify rural areas inside Metropolitan counties, and

3. The possible use of travel times along with RUCAs to identify census tracts inside Metropolitan counties as rural rather than using tract size and population density.

DATES: The public is encouraged to submit written comments on the report and its recommendations July 2, 2007.

ADDRESSES: The following mailing address should be used: Office of Rural Health Policy, Health Resources and Services Administration, 5600 Fishers Lane, Parklawn Building, 9A–55, Rockville, MD 20857. HRSA/ORHP's facsimile number is (301) 443–2803. Comments can also be sent via e-mail to *shirsch@hrsa.hhs.gov.* All public comments received will be available for public inspection at ORHP/HRSA's office between the hours of 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Questions about this request for public comment can be directed to Steven Hirsch, by e-mail (*shirsch@hrsa.hhs.gov*) or at the address above.

Dated: April 25, 2007.

Elizabeth M. Duke,

Administrator.

[FR Doc. E7–8492 Filed 5–2–07; 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: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Substance Abuse Prevention and Treatment Block Grant Synar Report Format, FFY 2005–2007—(OMB No. 0930–0222)—Revision

Section 1926 of the Public Health Service Act [42 U.S.C. 300x–26] stipulates that funding Substance Abuse Prevention and Treatment (SAPT) Block Grant agreements for alcohol and drug abuse programs for fiscal year 1994 and subsequent fiscal years require States to have in effect a law providing that it is unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18. This section further requires that States conduct annual, random, unannounced inspections to ensure compliance with the law; that the State submit annually a report describing the results of the inspections, describing the activities carried out by the State to enforce the required law, describing the success the State has achieved in reducing the availability of tobacco products to individuals under the age of 18, and describing the strategies to be utilized by the State for enforcing such law during the fiscal year for which the grant is sought.

Before making an award to a State under the SAPT Block Grant, the Secretary must make a determination that the State has maintained compliance with these requirements. If a determination is made that the State is not in compliance, penalties shall be applied. Penalties ranged from 10 percent of the Block Grant in applicable year 1 (FFY 1997 SAPT Block Grant Applications) to 40 percent in applicable year 4 (FFY 2000 SAPT Block Grant Applications) and subsequent years. Respondents include the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, Micronesia, and the Marshall Islands.

Regulations that implement this legislation are at 45 CFR 96.130, are approved by OMB under control number 0930–0163, and require that each State submit an annual Synar report to the Secretary describing their progress in complying with section 1926 of the PHS Act. The Synar report, due December 31 following the fiscal year for which the State is reporting, describes the results of the inspections and the activities carried out by the State to enforce the required law; the success the State has achieved in

reducing the availability of tobacco products to individuals under the age of 18; and the strategies to be utilized by the State for enforcing such law during the fiscal year for which the grant is sought.

SAMHSA's Center for Substance Abuse Prevention will request OMB approval of revisions to the current report format associated with Section 1926 (42 U.S.C. 300x–26). The report format is changing significantly. Any changes in either formatting or content are being made to simplify the reporting process for the States and to clarify the information as the States report it; both outcomes will facilitate consistent, credible, and efficient monitoring of Synar compliance across the States and will reduce the reporting burden by the States. All of the information required in the new report format is already being collected by the States.

ANNUAL REPORTING BURDEN

45 CFR Citation	Number of respondents [1]	Responses per respondents	Hours per response	Total hour burden
Annual Report (Section 1—States and Territories) 96.130(e)(1–3)	59	1	15	885
State Plan (Section II—States and Territories) 96.130(e)(4,5)96.130(g)	59	1	3	177
Total	59			1,062

[1] Red Lake Indian Tribe is not subject to tobacco requirements.

Send comments to Summer King, SAMHSA Reports Clearance Officer, Room 7–1044, One Choke Cherry Road, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: April 27, 2007.

Elaine Parry,

Acting Director, Office of Program Services.

[FR Doc. E7–8450 Filed 5–2–07; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

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Proposed Project: 2008 National Survey on Drug Use and Health—(OMB No. 0930–0110)—Revision

The National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey on Drug Abuse (NHSDA), is a survey of the civilian, non-institutionalized population of the United States 12 years old and older. The data are used to determine the prevalence of use of tobacco products, alcohol, illicit substances, and illicit use of prescription drugs. The results are used by SAMHSA, ONDCP, Federal government agencies, and other organizations and researchers to establish policy, direct program activities, and better allocate resources.

For the 2008 NSDUH, additional questions are being planned regarding suicide ideation and impairment from mental health issues. An embedded split-sample study is being planned to determine which one of two mental health disability scales to include in future NSDUH survey years. The two disability scales will be evaluated by using the SCID–I/NP as a follow-up interview with a subsample of respondents.

Other questionnaire changes include deletion of questions about Hurricanes Katrina and Rita, adoption of a reduced set of income questions which were tested in 2006 and 2007, and routing of Adderall, Ambien, Ketamine, DMT, AMT, ''Foxy'' and salvia divinorum users into the questions on drug dependence and abuse. For half of the adult population, the respondent burden will remain at 60 minutes per interview. However, due to the length of one of the disability scales, the other half of the adult population may have respondent burden of up to 61 minutes.

As with all NSDUH/NHSDA surveys conducted since 1999, the sample size of the survey for 2008 will be sufficient to permit prevalence estimates for each of the fifty states and the District of Columbia. The total annual burden estimate is shown below:

Activity	Number of respondents	Number of responses per respondent	Average burden hours per respondent	Total burden hours
Household Screening	182,250	1	.083	15,127
Interview	67,500	1	1.0	67,500
Clinical Follow-up	1,500	1	1.0	1,500
Screening Verification	5,494	1	.067	368
Interview Verification	10,125	1	.067	678
TOTAL	182,250			853,173