the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2015 notice reflect the 1.6 percent price increase between calendar years 2013 and 2014. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2015 guidelines are roughly equal to the poverty thresholds for calendar year 2014 which the Census Bureau expects to publish in final form in September 2015.)

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's new Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

For families/households with more than 8 persons, add $4,160 for each additional person.

2015 POVERTY GUIDELINES FOR ALASKA

Persons in family/household	Poverty guideline
1	$14,720
2	19,920
3	25,120
4	30,320
5	35,520
6	40,720
7	45,920
8	51,120

For families/households with more than 8 persons, add $5,200 for each additional person.

2015 POVERTY GUIDELINES FOR HAWAII

Persons in family/household	Poverty guideline
1	$13,550
2	18,330
3	23,110
4	27,890
5	32,670
6	37,450
7	42,230
8	47,010

For families/households with more than 8 persons, add $4,780 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ''income'' or ''family,'' because there is considerable variation in defining these terms among the different programs that use the guidelines. These variations are traceable to the different laws and regulations that govern the various programs. This means that questions such as ''Is income counted before or after taxes?'', ''Should a particular type of income be counted?'', and ''Should a particular person be counted as a member of the family/household?'' are actually questions about how a specific program applies the poverty guidelines. All such questions about how a specific program applies the guidelines should be directed to the entity that administers or funds the program, since that entity has the responsibility for defining such terms as ''income'' or ''family,'' to the extent that these terms are not already defined for the program in legislation or regulations.

Dated: January 16, 2015.

Sylvia M. Burwell,

Secretary of Health and Human Services.

[FR Doc. 2015–01120 Filed 1–21–15; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–15–15KX]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction

Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan and instruments, call 404–639–7570 or send comments to Leroy A. Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. Comments are invited on: (a) Whether the proposed collection of information is 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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

Proposed Project

Assessing Community-Based Organizations' Partnerships with Schools for the Prevention of HIV/STDs—New—Division of Adolescent and School Health (DASH), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC).

Background and Brief Description

HIV infections remain high among young men who have sex with men (YMSM). The estimated number of new HIV infections increased between 2008 and 2010 both overall and among MSM ages 13 to 24. Furthermore, sexual risk behaviors associated with HIV, other sexually transmitted disease (STD), and pregnancy often emerge in adolescence. For example, 2011 Youth Risk Behavior Surveillance System (YRBSS) data revealed 47.4% of U.S. high school students reported having had sex, and among those who had sex in the previous three months, 39.8% reported having not used a condom during last sexual intercourse. In addition, 2001–2009 YRBSS data revealed high school students identifying as gay, lesbian, and bisexual and those reporting sexual contact with both males and females were more likely to engage in sexual risk-taking behaviors than heterosexual students.

Given the disproportionate risk for HIV among YMSM ages 13–24, it is important to find ways to reach the younger youth (*i.e.,* ages 13–19) in this range to decrease sexual risk behaviors and increase health-promoting behaviors such as routine HIV testing. Schools provide one opportunity for this. Because schools enroll more than 22 million teens (ages 14–19) and often have existing health and social services infrastructure, schools and their staff members are well-positioned to connect youth to a wide range of needed services, including housing assistance, support groups, and sexual health services such as HIV testing. As a result, CDC's DASH has focused a number of HIV and STD prevention efforts on strategies that can be implemented in or centered on schools.

However, conducting HIV and STD prevention work (particularly work that is designed to specifically meet the needs of YMSM), can be challenging. School is not always a welcoming environment for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Harassment, bullying, and verbal and physical assault are often reported, and such unsupportive environments and victimization among LGBT youth are associated with a variety of negative outcomes, including truancy, substance use, poor mental health, HIV and STD risk, and even suicide. Schools build partnerships with community-based organizations to increase access to needed services of LGBTQ youth.

The CDC requests a 3-year OMB approval to conduct a new information collection entitled, ''Assessing Community-Based Organizations' Partnerships with Schools for the Prevention of HIV/STDs.'' The information collection will allow CDC to conduct assessment of selected staff from community-based organizations (CBOs) and health and/or wellness centers (HWCs), including school-based health centers, at participating schools or to which YMSM from participating schools are referred. This is part of the HIV and STD prevention efforts that are taking place in conjunction with local education agencies (LEAs) funded by the CDC, Division of Adolescent and School Health (DASH) under strategy 4 (School-Centered HIV/STD Prevention for Young Men Who Have Sex with Men) of PS13–1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance.* This information collection will provide data and reports for the three funded LEAs, and will allow each LEA to identify areas of the partnerships with CBOs and HWCs that are working well and other areas that will need additional improvement. In addition, the findings will allow the CDC to determine the potential impact of currently recommended strategies and make changes to those recommendations if necessary.

This information collection system involves administration of a web-based questionnaire to no more than 60 total staff members who work for up to 60 CBOs and HWCs that are participating in the HIV/STD prevention project with the three LEAs (Broward County Public Schools in Broward County, Florida; Los Angeles Unified School District in Los Angeles, California; and San Francisco Unified School District in San Francisco, California) funded by CDC cooperative agreement PS13–1308. These LEAs represent all funded LEAs under Strategy 4 of PS13–1308. The questionnaire will include questions on the following topics: services offered by the organization and the organization's relationships with the school district and participating schools in the LEA.

The Web-based instrument will be administered in the 2015 and again in 2016 and 2018. These data collection points coincide with the initiation of project activities, the mid-way point, and endpoint of the PS13–1308 cooperative agreement. Although some respondents may participate in the data collection in multiple years, this is not a longitudinal design and individual staff member responses will not be tracked across the years. No personally identifiable information will be collected and data will only be reported in the aggregate to protect the CBOs and HWCs being represented.

All respondents will receive informed consent forms prior to participation in the information collection. The consent form explains the study and also explains that participants may choose not to complete the Web-based questionnaire with no penalty and no impact on their job or relationship with the LEA. Participation is completely voluntary.

For the Web-based questionnaire, the estimated burden per response is about 60 minutes (1 hour). This estimate of burden is an average and takes into account that the length of the questionnaire for each respondent will vary slightly due to the skip patterns that may occur with certain responses, variations in the reading speed of respondents, and variations in the time required to collect the information needed to complete the questionnaire.

The estimated annualized burden of this data collection is 60 hours for respondents.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZE BURDEN TO RESPONDENTS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
CBO staff	CBO Assessment Questionnaire	30	1	1	30
HWC staff	HWC Assessment Questionnaire	30	1	1	30
Total					60

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2015–01009 Filed 1–21–15; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–15–0929]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan and instruments, call 404–639–7570 or send comments to LeRoy Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. Comments are invited on: (a) Whether the proposed collection of information is 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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

Proposed Project

World Trade Center Health Program Petition for the Addition of a New WTC-Related Health Condition for Coverage under the World Trade Center (WTC) Health Program (OMB No. 0920–0929, expires 4/30/2015)—Revision—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Title I of the James Zadroga 9/11 Health and Compensation Act of 2010 (Pub. L. 111–347), amended the Public Health Service Act (PHS Act) to add Title XXXIII establishing the WTC Health Program within the Department of Health and Human Services (HHS).

The WTC Health Program provides medical monitoring and treatment benefits to eligible firefighters and related personnel, law enforcement officers, and rescue, recovery, and cleanup workers who responded to the September 11, 2001, terrorist attacks in New York City, at the Pentagon, and in Shanksville, Pennsylvania (responders), and to eligible persons who were present in the dust or dust cloud on September 11, 2001 or who worked, resided, or attended school, childcare, or adult daycare in the New York City disaster area (survivors). PHS Act § 3312(a)(3) identifies a list of health conditions for which individuals who are enrolled in the WTC Health Program may be monitored or treated. PHS Act § 3312(a)(6)(B) specifies that interested parties may petition the Administrator of the WTC Health Program to request that a new health condition be added to the List of WTC-Related Health Conditions in 42 CFR 88.1.

To aid the petitioner, the WTC Health Program provides a petition form to be completed and then sent to the Administrator for review. However, the petitioner is not required to use the form, and may submit a petition in a different format, provided it contains all of the data elements requested on the form. Data elements include the interested party's name, contact information, signature, and a statement about the medical basis for the relationship/association between the 9/11 exposure and the proposed health condition, which the Administrator of the WTC Health Program will use to determine whether to propose a rule to add the condition, to not to add the condition, or to seek a recommendation