Background: The WTCHP is administered by NIOSH. The James Zadroga 9/11 Health and Compensation Act of 2010, Public Law 111–347 (hereafter referred to as ''the Zadroga Act'') was signed by President Obama on January 2, 2011, and was re-authorized on December 18, 2015. The Zadroga Act continues monitoring and treatment activities and requires the establishment (under Subtitle C) of a research program on health conditions resulting from the September 11, 2001, terrorist attacks. For additional information on the program please refer to: *http://www.cdc.gov/wtc.*

The Zadroga Act lists the following broad research areas:

- Physical and mental health conditions that may be related to the September 11, 2001, terrorist attacks;
- Diagnosing WTC-related health conditions for which there has been diagnostic uncertainty; and
- Treating WTC-related health conditions for which there has been treatment uncertainty.

Research mentioned in the Zadroga Act includes epidemiologic and other research studies on WTC-related health conditions or emerging conditions among (1) enrolled WTC responders and certified-eligible WTC survivors under treatment; (2) sampled populations outside the NYC disaster area, in Manhattan (as far north as 14th Street) and in Brooklyn; and (3) control populations, to identify potential for long-term adverse health effects in less exposed populations.

Major areas of interest include, but are not limited to, the following:

Linking 9/11 exposure to health conditions:

- Cancers, multisystem or autoimmune, cardiovascular and neurologic disease (including age at diagnosis);
- Characterizing patterns of illness (age, gender, comorbidities, etc.); and
- Characterizing alterations in health and development for those exposed to 9/11 as children.

Characterizing established WTC-related diseases and comorbidities:

- Identifying phenotypes, biomarkers, epigenetics; and
- Care models that address complex co-morbidities and other modifiable factors.
- Health services research and value-based care that addresses disaster-related injury and illness for chronic disease.

(**Note:** Health services research *examines how people get access to health care, how much care costs, and what happens to patients as a result of this care. The main goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care; reduce medical errors; and improve patient safety (Agency for Healthcare Research and Quality, 2002*).

Characterizing the work-ability and occupational outcomes for those impacted by 9/11.

Lessons learned in recovery:

- Identifying and operationalizing key elements of psychological resilience for disaster responders; and
- Establishing comparison groups for disaster-related research for key health indicators for first responders.

(**Note:** Concepts of psychological resilience *vary across disciplines with investigations addressing various outcomes ranging from reported levels of stress, burnout, compassion fatigue, and general indicators of well-being. Also proposed are interpersonal, intrapersonal and environmental factors that suggest a more stable and enduring personality trait impacting self-regulation.*)

Relevant diseases or conditions include, but are not limited to, the following:

- Respiratory diseases
- Cancer (including detection/diagnosis of pre-malignant changes)
- Cardiovascular Disease
- Psychological resilience and well-being
- Persistent psychiatric conditions such as posttraumatic stress, anxiety and depressive disorders
- Cognitive changes
- Aging—the impacts of aging on those impacted by 9/11 illness and injury
- Neurological Diseases
- Aerodigestive health
- Multisystem or auto-immune diseases
- Gastro-esophageal disorders
- Gastrointestinal health
- Chronic musculoskeletal conditions resulting from acute traumatic injury and overuse disorders

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2017–22436 Filed 10–16–17; 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: Form ACF–196R, ''TANF Quarterly Financial Report''

OMB No.: 0970–0446

Description: This information collection is authorized under Section 411(a)(3) of the Social Security Act. This request is for continued approval of Form ACF–196R for quarterly financial reporting under the Temporary Assistance for Needy Families (TANF) program. States participating in the TANF program are required by statute to report financial data on a quarterly basis. The forms meet the legal standard and provide essential data on the use of federal TANF funds. Failure to collect the data would seriously compromise ACF's ability to monitor program expenditures, estimate funding needs, and to prepare budget submissions and annual reports required by Congress. Financial reporting under the TANF program is governed by 45 CFR part 265.

This form was first developed in 2014 to replace Form ACF–196. No changes are being proposed with this request for OMB review. No comments were received in response to the publication of the initial **Federal Register** Notice on May 30, 2017, 82 FR 24714.

Respondents: State agencies administering the TANF program (50 States plus the District of Columbia)

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF–196R	51	4	14	2,856

Estimated Total Annual Burden Hours: 2,856.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 330 C Street SW., Washington, DC 20201, Attn: Reports Clearance Officer. All requests should be identified by the title of the information collection. Email 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, Email: *OIRA_SUBMISSION@OMB.EOP.GOV*, Attn: Desk Officer for the Administration for Children and Families.

Mary Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2017–22377 Filed 10–16–17; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: National Child Abuse and Neglect Data System.

OMB No.: 0970–0424.

Description: The Administration on Children, Youth and Families in the U.S. Department of Health and Human Services (HHS) established the National Child Abuse and Neglect Data System (NCANDS) to respond to the 1988 and 1992 amendments (Pub. L. 100–294 and Pub. L. 102–295) to the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 *et seq.*), which called for the creation of a coordinated national data collection and analysis program, both universal and case specific in scope, to examine standardized data on false, unfounded, or unsubstantiated reports.

In 1996, the Child Abuse Prevention and Treatment Act was amended by Public Law 104–235 to require that any state receiving the Basic State Grant work with the Secretary of the Department of Health and Human Services (HHS) to provide specific data on child maltreatment, to the extent practicable. These provisions were retained and expanded upon in the 2010 reauthorization of CAPTA (Pub. L. 111–320). Item (17) below was enacted with the Justice for Victims of Trafficking Act of 2015 (Pub. L. 114–22). The law goes into effect in 2017 and it is anticipated that states will begin reporting with FFY 2018 data. Item (18) below was enacted with the Comprehensive Addiction and Recovery Act of 2016 (CARA) (Pub. L. 114–198). The law goes into effect in 2017 and it is anticipated that states will begin reporting with FFY 2018 data. Each state to which a grant is made under this section shall annually work with the Secretary to provide, to the maximum extent practicable, a report that includes the following:

1. The number of children who were reported to the state during the year as victims of child abuse or neglect.

2. Of the number of children described in paragraph (1), the number with respect to whom such reports were—

A. substantiated;

B. unsubstantiated; or

C. determined to be false.

3. Of the number of children described in paragraph (2)—

A. the number that did not receive services during the year under the state program funded under this section or an equivalent state program;

B. the number that received services during the year under the state program funded under this section or an equivalent state program; and

C. the number that were removed from their families during the year by disposition of the case.

4. The number of families that received preventive services, including use of differential response, from the state during the year.

5. The number of deaths in the state during the year resulting from child abuse or neglect.

6. Of the number of children described in paragraph (5), the number of such children who were in foster care.

7.

A. The number of child protective service personnel responsible for the—

i. intake of reports filed in the previous year;

ii. screening of such reports;

iii. assessment of such reports; and

iv. investigation of such reports.

B. The average caseload for the workers described in subparagraph (A).

8. The agency response time with respect to each such report with respect to initial investigation of reports of child abuse or neglect.

9. The response time with respect to the provision of services to families and children where an allegation of child abuse or neglect has been made.

10. For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the state—

A. information on the education, qualifications, and training requirements established by the state for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;

B. data of the education, qualifications, and training of such personnel;

C. demographic information of the child protective service personnel; and

D. information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor.

11. The number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or neglect, including the death of the child.

12. The number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.

13. The annual report containing the summary of activities of the citizen review panels of the state required by subsection (c)(6).

14. The number of children under the care of the state child protection system who are transferred into the custody of the state juvenile justice system.

15. The number of children referred to a child protective services system under subsection (b)(2)(B)(ii).

16. The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 *et seq.*).

17. The number of children determined to be victims described in subsection (b)(2)(B)(xxiv).

18. The number of infants—

(A) identified under subsection (b)(2)(B)(ii);

(B) for whom a plan of safe care was developed under subsection (b)(2)(B)(iii); and

(C) for whom a referral was made for appropriate services, including services for the affected family or caregiver, under subsection (b)(2)(B)(iii).