State for the review. Applicants (other than federally-recognized Indian tribal governments) should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the appropriate deadline dates. The BPHC does not guarantee that it will accommodate or explain its responses to State process recommendations received after the date. (See ''Intergovernmental Review of Federal Programs'', Executive Order 12372, and 45 CFR part 100 for a description of the review process and requirements.)

(The OMB Catalog of Federal Domestic Assistance number for this program is 93.918.)

Dated: April 17, 1997.

Claude Earl Fox,

Acting Administrator.

[FR Doc. 97–10473 Filed 4–22–97; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Rural Telemedicine Grant Program

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

ACTION: Notice of availability of funds.

SUMMARY: The Office of Rural Health Policy, HRSA, announces that applications are being accepted for Rural Telemedicine Grants to facilitate development of rural health care networks through the use of telemedicine and develop a baseline of information for the systematic evaluation of telemedicine systems serving rural areas.

DATES: Applications for the program must be received by the close of business on June 20, 1997. Applications shall be considered as meeting the deadline if they are either (1) received on or before the deadline date at the address noted below; or (2) postmarked on or before the deadline date and received by the granting agency in time for the independent review. Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service in lieu of a postmark. Private metered postmarks shall not be acceptable as proof of timely mailing. Applications are considered late if they do not meet the above criteria; late applications will be returned to the sender.

ADDRESSES: Completed applications must be sent to HRSA GRANTS APPLICATION CENTER, 40 West Gude Drive, Suite 100, Rockville, MD 20850.

FOR FURTHER INFORMATION CONTACT: Requests for technical or programmatic information on this announcement should be directed to Cathy Wasem or Amy Barkin, Office of Rural Health Policy, HRSA, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857, (301) 443–0835, cwasem@hrsa.dhhs.gov or abarkin@hrsa.dhhs.gov. Requests for information regarding business or fiscal issues should be directed to Martha Teague, Office of Grants Management, Bureau of Primary Health Care, HRSA, West Tower, 11th Floor, 4350 East West Highway, Bethesda, MD 20814, (301) 594–4258.

SUPPLEMENTARY INFORMATION:

Application Packet

The standard application form and general instructions for completing applications (Form PHS–5161–1 [Revised 5/96], OMB #0937–0189) have been approved by the Office of Management and Budget. To receive an application kit call toll-free: HRSA GRANTS APPLICATION CENTER at 1–888–300–HRSA. Individuals in rural areas where the 1–888 number cannot be dialed should call the operator and ask that the operator connect them to 1–888–300–4772.

Authority

Grants for these projects are authorized under section 330A of the Public Health Service (PHS) Act as amended by the Health Centers Consolidation Act of 1996, Public Law 104–299. Awards will be made from funds appropriated under Public Law 104–208 (HHS Appropriation Act for FY 1997).

Legislative and Program Background

Section 330A of the PHS Act, as amended by Pub. L. 104–299, authorizes the Rural Health Outreach, Network Development and Telemedicine Grant Program. Grants supported under this program are to ''expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions.'' Two approaches to achieve these goals are through projects funded under the Rural Health Outreach and the Rural Network Development Program. A third approach is through projects funded under the Rural Telemedicine Grant Program. This program announcement pertains only to the Rural Telemedicine Grant Program. (The **Federal Register** Notice for the Rural Health Outreach and Rural Network Development Program was published December 13, 1996. Applications were due March 31, 1997).

Rural residents in the United States often lack access to a range of health services—from basic preventive services to highly specialized services—that would enable them to prevent, recover from, or cope with disease and disability. Consistent with the legislation, the Office of Rural Health Policy (ORHP) views integrated health care delivery systems or networks as a means to stabilize and integrate fragile rural health care systems with more sustainable, comprehensive delivery networks. ORHP believes that telemedicine has the potential to facilitate the development of integrated health care networks, thereby fostering improved access to quality health care services and reducing the isolation of rural practitioners.

The goal of ORHP's Rural Telemedicine Grant Program is to improve access to quality health services for rural residents and reduce the isolation of rural practitioners through the use of telemedicine technologies.

The two objectives of the Rural Telemedicine Grant Program are: (1) To demonstrate how telemedicine can be used as a tool in developing integrated systems of health care, thereby improving access to health services for rural individuals across the lifespan and reducing the isolation of rural health care practitioners; and (2) to evaluate the feasibility, costs, appropriateness, and acceptability of rural telemedicine services and technologies. Such evaluation is needed to determine how best to organize and provide telemedicine services in a sustainable manner.

Under its Rural Telemedicine Grant Program, ORHP funded eleven telemedicine projects in fiscal year 1994 for a period of three years. Building on the lessons learned from these first telemedicine grantees, new grantees will be expected to further the development of integrated health care networks by using telemedicine to increase access to a wide range of clinical services based on community need.

Funds Available

Approximately $4 million is available for the Rural Telemedicine Grant program in FY 1997. The Office of Rural

Health Policy expects to make approximately 10–14 new awards. Applicants may propose project periods of up to three years. However, applicants are advised that continued funding of grants beyond FY 1997 is subject to the availability of funds and grantee performance. No project will be supported for more than three years. The budget period for new projects will begin September 30, 1997.

Size of Awards

Individual grant awards under this notice will be limited to $400,000 (including direct and indirect costs) per year. It is anticipated that existing telemedicine networks would come in for smaller grant awards, because the network would already have some equipment and would be supporting some personnel. Overall, applications for smaller amounts are strongly encouraged.

Definitions

For the purposes of this grant program the following definitions apply:

Telemedicine: Telemedicine is the use of telecommunication and information technologies for the clinical care of patients, including patient counseling and clinical supervision/preceptorship of medical residents and health professions students, when such supervising or precepting involves direct patient care.

The definition does not include didactic distance education, such as lectures that are designed solely to instruct health care students, personnel or patients, and in which no clinical care is provided.

Telemedicine Clinical Consultation: A telemedicine clinical consultation is a person-to-person interaction relating to the clinical condition or treatment of a patient. It is the process by which a clinical service is delivered. The consultation may be interactive (i.e., in real-time) or asynchronous (i.e., using store-and-forward technology).

Professionals from a variety of health care disciplines may be involved in providing and/or receiving consultations including, but not limited to: physicians, physician assistants, nurses, nurse practitioners, nurse-midwives, clinical nurse specialists, dentists, dental hygienists, physical therapists, occupational therapists, speech therapists, clinical psychologists, clinical social workers, substance abuse counselors, podiatrists, optometrists, dieticians/nutritionists, pharmacists, optometrists, EMTs, etc.

Telemedicine Network: A telemedicine network is comprised of hubs (i.e., entities whose health care professionals provide consultations or whose faculty supervise or precept health professions students for clinical care at rural facilities) and spokes (i.e., entities whose professionals or patients receive consultations). Some entities may function as both a hub and a spoke. The network may have additional members who do not directly receive or provide consultations, but who foster access to and coordination of services, such as area agencies on aging and providers under the WIC program.

Rural spokes may be health care facilities or places in which health care is provided such as schools and homes. Examples of spoke sites include rural hospitals, clinics, nursing homes, mental health centers, homes, public health clinics, school-based clinics, assisted living facilities, senior citizen housing, and centers for the developmentally disabled.

Program Requirements

Telemedicine Network

In order to compete for the program, applicants must participate in a telemedicine network that includes at least three members: (1) a multispecialty entity (i.e., hub) located in an urban or rural area that can provide 24-hour-a-day access to a range of specialty health care; and (2) at least two rural health facilities (i.e., spokes), which may include small rural hospitals (fewer than 100 staffed beds), rural physician offices, rural health clinics, rural community health centers and rural nursing homes. For the purposes of this grant program, a multispecialty entity may be a tertiary care hospital, a multispecialty clinic, or a collection of facilities that, combined, could provide 24-hour-a-day specialty consultations.

A telemedicine network is characterized by a partnership among its members that is evidenced by each member's: (1) resource contribution; (2) specific network role; (3) active planning and programmatic participation; (4) long-term commitment to the project; and (5) signature on a signed, dated memorandum of agreement.

Applicants are encouraged to include other types of members in their network such as mental health clinics, public health clinics and departments, school-based clinics, emergency service providers, health professions schools, home health providers, and social service programs such as area agencies on aging and providers under the WIC program. Preference will be given to applicants whose networks meet the statutory preference noted in the ''Statutory Preference Section.''

Clinical Services

An applicant must meet the following programmatic requirements for clinical services:

(1) It must provide a minimum of seven (7) clinical telemedicine services over the network, one of which must be the stabilization of patients in emergency situations. Not all services need be provided to all sites.

(2) The applicant and its network members should select the other six (6) services to be provided. These services must be based on documented needs of the communities to be served.

(3) In addition to emergency stabilization services, at least two of the grant-funded services provided by the telemedicine network must be consultant services provided by physician specialists.

(4) All services provided with funding from this grant program must be available from the multispecialty entity on a 24-hour-a-day basis unless there is a strong justification for services being available less than 24 hours-a-day. An entity is considered capable of providing specialty consultations 24-hours-a-day if they have specialists on-call.

System Design

All members of a telemedicine network will be required to be electronically linked, for at least e-mail services, by the ninth month of the first budget period.

Whenever possible, telemedicine systems should be designed with an open architecture, fostering interoperability with other telemedicine systems.

Telemedicine systems should be designed using the least costly, most efficient technology to meet the identified need(s).

ORHP grant recipients will be expected, during the first nine months of the first budget period, to develop a set of protocols for each of the clinical services to be provided using telemedicine.

Evaluation and Data Collection

An applicant must submit a plan for evaluating the telemedicine services it provides and monitoring its own performance, as well as participate in an ORHP-sponsored evaluation of telemedicine services. The ORHP-sponsored activities may include maintaining a data-log provided by ORHP and collecting data, completing surveys, and participating in on-site observations by independent evaluators. The ORHP-sponsored data activities will be subject to OMB approval under the Paperwork Reduction Act of 1995.

Funding Requirements

Use of Grant Funds

Grant funds may be used to support the operating costs of the telemedicine system, including compensation for consulting and referring practitioners.

Grant funding must be used for services provided to or in rural communities. Fifty percent (50%) or more of the grant award must be spent for: transmission costs and clinician compensation payments; costs incurred in rural communities, including rural staff salaries and equipment maintenance; and equipment placed in rural communities, irrespective of where the equipment is purchased.

Grant dollars may not be used to support didactic distance education activities. However, equipment purchased to provide clinical services may be used for a variety of non-clinical purposes, including didactic education, administrative meetings, etc.

No more than forty percent (40%) of the total grant award each year may be used to purchase, lease or install equipment (i.e., equipment used inside the health care facility for providing telemedicine services such as codecs, cameras, monitors, computers, multiplexers, etc.).

Grant funds may not be used to purchase or install transmission equipment, such as microwave towers, satellite dishes, amplifiers, digital switching equipment or laying cable or telephone lines.

Grant funds may not be used to build or acquire real property, or for construction or renovation, except for minor renovations related to the installation of equipment.

Grant funds may be used to pay for transmission costs such as the cost of satellite time or the use of phone lines. However, those applicants who anticipate very high transmission rates for all or some of their sites should consider activities to achieve more sustainable rates.

If ORHP funds are used for clinician compensation payments, payments can be up to a maximum of $60 per practitioner per consult. If a third-party payer, including Medicaid or Medicare, can be billed for a consult, the grantee may not provide the practitioner with an ORHP-funded compensation payment. This requirement applies even if the grantee has not yet established its own internal procedure to bill Medicaid or Medicare.

Indirect Costs

In accordance with the law, no more than 20 percent of the amount provided under a grant in this grant program can be used to pay for the indirect costs associated with carrying out the purposes of such grant.

Cost Participation

The amount of cost participation will serve as an indicator of community and institutional support for the project and of the likelihood that the project will continue after federal grant support has ended. Cost participation may be in cash or in-kind (e.g., equipment, personnel, building space, indirect costs).

If an award is made, all funds identified as dedicated to this project (including funds used for cost participation) will be subject to the applicable cost principles, audit and reporting requirements.

Eligible Applicants

A grant award will be made either (1) to an entity that is a health care provider and is a member of an existing or proposed telemedicine network, or (2) to an entity that is a consortium of health care providers that are members of an existing or proposed telemedicine network. The applicant must be a legal entity capable of receiving federal grant funds. The grant recipient must be a public (non-federal) or private nonprofit entity, located in either a rural or urban area. Other telemedicine network members may be public or private, nonprofit or for-profit. Health facilities operated by a Federal agency may be members of the network but not the applicant.

All spoke facilities supported by this grant must meet one of the two criteria stated below:

(1) The facility is located outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. (A list of the cities and counties that are designated as Metropolitan Statistical Areas is included in the application kit); or

(2) The facility is located in one of the specified rural census tracts of the MSA counties listed in Appendix I. Although each of these counties is an MSA, or part of one, large parts of each county are rural. Facilities located in these rural areas are eligible for the program. Rural portions of these counties have been identified by census tract because this is the only way we have found to clearly differentiate them from urban areas in the large counties. Appendix I provides a list of these eligible census tracts by county. Appendix II includes the telephone numbers for regional offices of the Census Bureau. Applicants may call these offices to determine the census tract in which they are located.

Statutory Funding Preference

As provided in section 330A of the PHS Act, as amended by the Health Centers Consolidation Act of 1996 (Pub. L. 104–299), an applicant will be given preference in the review process if its network includes any of the following:

(a) a majority of the health care providers serving in the rural areas or region to be served by the network;

(b) any federally qualified health centers, rural health clinics, and local public health departments serving in the rural area or region;

(c) outpatient mental health providers serving in the rural area or region; or

(d) appropriate social service providers (e.g., agencies on aging, school systems, and providers under the Women, Infants, and Children [WIC] program) to improve access to and coordination of health care services.

For preference purposes, the following definitions apply:

''Health care providers'' in 'element (a)' are defined as institutions and/or facilities that provide health care. ''Federally Qualified Health Centers (FQHCs)'' are defined as those federally and nonfederally-funded health centers that have status as federally qualified health centers under section 1861(aa)(4) or section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(4) and 1396d(l)(2)(B), respectively).

''Rural health clinics (RHCs)'' are defined as clinics certified by HCFA and approved to participate in the Medicare and Medicaid programs and receive payments as a Rural Health Clinic as defined under section 1861(aa) or 1905(l) of the Social Security Act (42 U.S.C. 1395x(aa) and 1395d(l), respectively).

Approved applications that qualify for the statutory funding preference will be funded ahead of other approved applications.

HRSA will consider geographic coverage when deciding which approved applications to fund. In addition, HRSA is concerned with assuring that grants to new networks, as well as to existing networks, be funded. Therefore when making awards, HRSA will consider the balance between awards to new telemedicine networks and to existing telemedicine networks.

Review Criteria

Grant applications will be evaluated on the basis of the following criteria:

(1) Extent to which the applicant has documented the need for the project, developed measurable project objectives for meeting the need, and developed a methodology or plan of activities that will lead to attaining the project objectives, including a plan to monitor the performance of the project. (20 points)

(2) Extent to which the project objectives and related activities are consistent with the goal and objectives of the grant program noted in the 'Legislative and Program Background' section. (35 points)

(a) Extent to which the proposed project will, using telemedicine as a tool, facilitate the development of an integrated rural health network, thereby increasing access to health services and decreasing practitioner isolation. (20 points)

(b) Extent to which the proposed project will provide a baseline of information and data for the systematic evaluation of telemedicine. (15 points)

(3) Demonstrated capability, experience and knowledge (i.e. managerial, technical, and clinical) of the applicant and other network members to implement the project and to disseminate information about the project. (20 points)

(4) Level of local involvement in defining needs and planning and implementing the project. Level of commitment to the project as evidenced by cost participation by the applicant, other network members and/or other organizations, and realistic plans to sustain the telemedicine network after federal grant support ends. (15 points)

(5) Relevance of the budget to the proposed activities and reasonableness of the budget to anticipated outcomes/results. (10 points)

Other Information

Applicants must develop projects that address specific, documented needs of the rural communities. Applicants should consider (1) the health care needs of the rural communities served by the project, (2) the information and support needs of rural health care practitioners, and (3) the extent to which the project can build upon existing telecommunications capacity in the communities. Needs can be established through a formal needs assessment, by population specific demographic and health data, and by health services data.

Applicants are advised that the narrative description of their program plus the narrative budget justification may not exceed 35 pages in length. All applications must be typewritten or printed and legible. Pages must have margins no less than one inch on top and one-half inch on the sides and bottom. The print font on each page, with the exception of the narrative budget pages, must be no smaller than 12 characters per inch (cpi) or a 12 point scalable font. The narrative budget pages must be no smaller than a 12 cpi or a 10 point scalable font.

Any application that is judged nonresponsive because it is inadequately developed, in an improper format, exceeds the specified page length, or otherwise is unsuitable for peer review and funding consideration, will be returned to the applicant. All responsive applications will be reviewed by an objective review panel.

National Health Objectives for the Year 2000

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, a PHS-led national activity for setting priority areas. The Rural Telemedicine Grant program is related to the priority areas for health promotion, health protection, and preventive services. Potential applicants may obtain a copy of Healthy People 2000 (Full Report: Stock No. 017–001–00474–0) or Healthy People 2000 (Summary Report: Stock No. 017–001–00473–1) through the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325 (Telephone (202) 783–3238).

Smoke-Free Workplaces

The PHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are offered to children.

Public Health System Impact Statement

This program is subject to the Public Health System Reporting Requirements as approved by the OMB—0937–0195. Under these requirements, the community-based nongovernmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based nongovernmental organizations within their jurisdictions.

Community-based nongovernmental applicants are required to submit the following information to the head of the appropriate State and local health agencies in the area(s) to be impacted: a. A copy of the face page of the application (SF 424) b. A summary of the project, not to exceed one page, which provides:

(1) A description of the population to be served.

(2) A summary of the services to be provided.

(3) A description of the coordination planned with the appropriate State of local health agencies.

This information must be submitted no later than the federal application receipt due date.

Executive Order 12372

The Rural Telemedicine Grant program has been determined to be a program that is subject to the provisions of Executive Order 12372 concerning intergovernmental review of federal programs by appropriate health planning agencies as implemented by 45 CFR part 100. Executive Order 12372 sets up a system for State and local government review of proposed federal assistance applications. Applicants (other than federally-recognized Indian tribal governments) should contact their State Single Point of Contact (SPOCs) as early as possible to alert the SPOC to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more then one State, the applicant is advised to contact the SPOC of each affected State. A list of SPOCs is included in the application kit. All SPOC recommendations should be submitted to Pam Hilton, Office of Grants Management, Bureau of Primary Health Care, 4350 East West Highway, 11th floor, Bethesda, Maryland, 20814, (301) 594–4260. The due date for State process recommendations is 60 days after the application deadline of June 20, 1997 for competing applications. The granting agency does not guarantee to ''accommodate or explain'' for State process recommendations it receives after that date. (See Part 148 of the PHS Grants Administration Manual, ''Intergovernmental Review of PHS Programs under Executive Order 12372 and 45 CFR Part 100,'' for a description of the review process and requirements.

Applicants should notify their State Office of Rural Health (or other appropriate State entity) of their intent to apply for this grant program and to consult with such agency regarding the content of the application. The State Office can provide information and technical assistance. A list of State Offices of Rural Health is included with the application kit.

OMB Catalog of Federal Domestic Assistance number is 93.211.

Claude Earl Fox,

Acting Administrator.

Appendix I

Census tract numbers are shown *below* each county name.

For a spoke health care facility to be eligible as 'rural' under criterion #2, the facility must be located in one of the census tracts (CTs) or block numbered areas (BNAs) that is listed below the following counties. If a facility is classified as rural under this criterion, the CT number or BNA number must be included next to the county name when identifying the facility in the 'Telemedicine Network Identification' portion of the application.

State, County and Tract Number

Alabama

Baldwin

101–102
106
110
114–116

Mobile

59
62
66
72.02

Tuscaloosa

107

Arizona

Coconino

16–25

Maricopa

101
405.02
507
611
822.02
5228
7233

*Mohave***

**See Below

Pima

44.05
48–49

Pinal

01–02
04–12

Yuma

105–107
110
112–113
115–116

California

Butte

24–36

El Dorado

301.01–301.02
302–303
304.01–304.02
305.01–305.03
306
310–315

Fresno

40
63
64.01
64.03
65–68
71–74
78–83
84.01–84.02

Kern

33.01–33.02
34–37
40–50
51.01
52–54
55.01–55.02
56–61
63

Los Angeles

5990
5991
9001–9002
9004
9012.02
9100–9101
9108.02
9109–9110
9200.01
9201
9202
9203.03
9301

Madera

01.02–01.05
02–04
10
11.98
12.98

Merced

01–02
03.01
04
05.01–05.02
06–08
19.98
20
21.98
22
23.01
24
24.75–24.98

Monterey

109
112–0113
114.01–0114.02
115

Placer

201.01–201.02
202–204
216–217
219–220

Riverside

421
427.02–427.03
429–432
444
452.02
453–455
456.01–456.02
457.01–457.02
458–462

San Bernardino

89.01–89.02
90.01–90.02
91.01–91.02
93–95
96.01–96.03
97.01
97.03–97.04
98–99
100.01–100.02
102.01–102.02
103
104.01–104.03
105–107

San Diego

189.01–189.02
190
191.01
208
209.01–209.02
210
212.01–212.02
213

San Joaquin

40
44–45
52.01–52.02
53.02–53.04
54–55

San Luis Obispo

100–106
107.01–107.02
108
114
118–122
124–126
127.01–127.02

Santa Barbara

18
19.03

Santa Clara

5117.04
5118
5125.01
5127

Shasta

126–127
1504

Sonoma

1506.04
1537.01
1541–1543

Stanislaus

01
02.01
32–35
36.05
37–38
39.01–39.02

Tulare

02–07

26
28
40
43–44

Ventura

01–02
46
75.01

Colorado

Adams

84
85.13
87.01

El Paso

38
39.01
46

Larimer

14
17.02
19.02
20.01
22

Mesa

12
15
18
19

Pueblo

28.04
32
34

Weld

19.02
20
24
25.01–25.02

Florida

Collier

111–114

Dade

115

Marion

02
04–05
27

Osceola

401.01–401.02
402.01–402.02
403.01–403.02
404
405.01–405.02
405.03
405.05
406

Palm Beach

79.01–79.02
80.01–80.02
81.01–81.02
82.01–82.02
82.03–83.01
83.02

Polk

125–127
142–144
152
154–161

Kansas

Butler

201–205
209

Louisiana

Rapides

106
135–136

Terrebonne

122–123

MINNESOTA

*Polk**

204–210
*9701–9704

St. Louis

105
112–114
121–135
137.01–137.02
138–139
141
151–155

Stearns

103
105–111

Montana

Cascade

105

Yellowstone

15–16
19

Nevada

Clark

57–59

Washoe

31.04
32
33.01–33.04
34

New Mexico

Dona Ana

14
19

*Nye***

**See Below

Sandoval

101–104
105.01

Santa Fe

101–102
103.01

*Valencia**

*9701
*9703–9706
*9708
*9711–9712

New York

Herkimer

101
105.02
107–109
110.01–110.02
111–112
113.01

North Dakota

Burleigh

114–115

Grand Forks

114–116
118

Morton

205

Oklahoma

Osage

103–108

Oregon

Clackamas

235–236
239–241
243

Jackson

24
27

Lane

01
05
07.01–07.02
08
13–16

Pennsylvania

Lycoming

101–102

South Dakota

Pennington

116–117

Texas

Bexar

1720
1821
1916

Brazoria

606
609–619
620.01–620.02
621–624
625.01–625.03
626.01–626.02
627–632

Harris

354
544
546

Hidalgo

223–228
230–231
243

Washington

Benton

116–120

Franklin

208

King

327–328
330–331

Snohomish

532
536–538

Spokane

101–102
103.01–103.02
133
138
143

Whatcom

110

Yakima

18–26

Wisconsin

Douglas

303

Marathon

17–18
20–23

Wyoming

Laramie

16–18

*This county is divided into Block Numbered Areas (BNAs), not Census Tracts (CTs).

**This entire county, although part of a large city MSA, is eligible as rural.

Appendix II

Bureau of The Census Regional Information Service

Atlanta, GA 404–730–3957
Alabama, Florida, Georgia
Boston, MA 617–424–0501
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Upstate New York
Charlotte, NC 704–344–6144
Kentucky, North Carolina, South Carolina, Tennessee, Virginia
Chicago, IL 708–562–1740
Illinois, Indiana, Wisconsin
Dallas, TX 214–767–7105
Louisiana, Mississippi, Texas
Denver, CO 303–969–7750
Arizona, Colorado, Nebraska, New Mexico, North Dakota, South Dakota, Utah, Wyoming
Detroit, MI 313–259–0056
Michigan, Ohio, West Virginia
Kansas City, KS 913–551–6711
Arkansas, Iowa, Kansas, Missouri, New Mexico, Oklahoma
Los Angeles, CA 818–904–6339
California
Philadelphia , PA 215–597–8313
Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
Seattle, WA 206–728–5314
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[FR Doc. 97–10435 Filed 4–22–97; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Notice of Meetings

Pursuant to Public Law 92–463, notice is hereby given of the following meetings of the SAMHSA Special Emphasis Panels (SEPs) I and II in May.

A summary of the meetings may be obtained from: Ms. Dee Herman, Committee Management Liaison, SAMHSA Office of Extramural Activities Review, 5600 Fishers Lane, Room 17–89, Rockville, Maryland 20857. Telephone: (301) 443–4783.

Substantive program information may be obtained from the individual named as Contact for the meetings listed below.

The first two meetings will be of the SEP II committee and will include the review, discussion and evaluation of individual contract proposals. These discussions could reveal personal information concerning individuals associated with the proposals and confidential and financial information about an individual's proposal. The discussions may also reveal information about procurement activities exempt from disclosure by statute and trade secrets and commercial or financial information obtained from a person and privileged and confidential. Accordingly, the meetings are concerned with matters exempt from mandatory disclosure in Title 5 U.S.C. 552b(c) (3), (4), and (6) and 5 U.S.C. App. 2, § 10(d).

Committee Name: SAMHSA Special Emphasis Panel II.

Meeting Date: May 7, 1997.

Place: DoubleTree Hotel, Rockville Room, 1750 Rockville Pike, Rockville, MD 20852.

Closed: May 7, 1997—9:00 a.m. to 5:00 p.m.

Contact: Roger Straw, Ph.D., 17–89, Parklawn Building, Telephone: (301) 443–1919, and FAX: (301) 443–3437.

Committee Name: SAMHSA Special Emphasis Panel II.

Meeting Date: May 8, 1997.

Place: Chevy Chase Holiday Inn, Terrace ''A'', 5520 Wisconsin Avenue, Chevy Chase, MD 20815.

Closed: May 8, 1997—9:00 a.m. to 1:00 p.m.

Contact: Constance M. Burtoff, 17–89, Parklawn Building, Telephone: (301) 443–2437 and FAX: (301) 443–3437.

The third meeting will be of the SEP I committee and will include the review, discussion and evaluation of individual grant applications. This discussion could reveal personal information concerning individuals associated with the applications. Accordingly, this meeting is concerned with matters exempt from mandatory disclosure in Title 5 U.S.C. 552b(c)(6) and 5 U.S.C. App. 2, § 10(d).

Committee Name: Special Emphasis Panel I.

Meeting Dates: May 19–20, 1997.

Place: Residence Inn—Bethesda, Gateway Room, 7335 Wisconsin Avenue, Bethesda, MD 20814.

Closed: May 19, 1997—9:00 a.m. to 5:00 p.m. May 20, 1997—9:00 a.m. to Adjournment

Panel: Center for Substance Abuse Treatment (CSAT) Cooperative Agreement for a Multi-site Study For Cannabis (Marijuana) Dependent Youth

Contact: Stanley Kusnetz, Room 17–89, Parklawn Building, Telephone: (301) 443–3042 and FAX: (301) 443–3437.

Dated: April 18, 1997.

Jeri Lipov,

Committee Management Officer, Substance Abuse and Mental Health Services Administration.

[FR Doc. 97–10544 Filed 4–22–97; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4033–N–02]

Notice of Proposed Information Collection for Public Comment

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: Comments due: June 23, 1997.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Oliver Walker, Housing, Department of Housing and Urban Development, 451 7th Street SW., Room 9116, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Carissa Janis, telephone number (202) 708–3291 (this is not a toll-free number)