DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–P–0257]

Determination That Theophylline Oral Solution, 80 Milligrams/15 Milliliters, Was Not Withdrawn From Sale for Reasons of Safety or Effectiveness

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) has determined that theophylline oral solution, 80 milligrams (mg)/15 milliliters (mL), was not withdrawn from sale for reasons of safety or effectiveness. This determination will allow FDA to approve abbreviated new drug applications (ANDAs) for theophylline oral solution, 80 mg/15 mL, if all other legal and regulatory requirements are met.

FOR FURTHER INFORMATION CONTACT: Nancy Hayes, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, rm. 6244, Silver Spring, MD 20993–0002, 301–796–3601.

SUPPLEMENTARY INFORMATION: In 1984, Congress enacted the Drug Price Competition and Patent Term Restoration Act of 1984 (Pub. L. 98–417) (the 1984 amendments), which authorized the approval of duplicate versions of drug products approved under an ANDA procedure. ANDA applicants must, with certain exceptions, show that the drug for which they are seeking approval contains the same active ingredient in the same strength and dosage form as the "listed drug," which is a version of the drug that was previously approved. ANDA applicants do not have to repeat the extensive clinical testing otherwise necessary to gain approval of a new drug application (NDA). The only clinical data required in an ANDA are data to show that the drug that is the subject of the ANDA is bioequivalent to the listed drug.

The 1984 amendments include what is now section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)), which requires FDA to publish a list of all approved drugs. FDA publishes this list as part of the "Approved Drug Products With Therapeutic Equivalence Evaluations," which is generally known as the "Orange Book." Under FDA regulations, drugs are removed from the list if the Agency withdraws or suspends approval of the drug's NDA or ANDA for reasons of safety or effectiveness or if FDA determines that the listed drug was withdrawn from sale for reasons of safety or effectiveness (21 CFR 314.162). Under § 314.161(a)(1) (21 CFR 314.161(a)(1)), the Agency must determine whether a listed drug was withdrawn from sale for reasons of safety or effectiveness before an ANDA that refers to that listed drug may be approved. FDA may not approve an ANDA that does not refer to a listed drug.

Theophylline oral solution, 80 mg/15 mL, is the subject of ANDA 087449, held by Roxane Laboratories, Inc. (Roxane), and initially approved on September 15, 1983. ANDA 087449 was identified in the Orange Book as the listed drug for theophylline oral solution, 80 mg/15 mL.

According to the latest version of the approved labeling for theophylline oral solution, 80 mg/15 mL, theophylline is indicated for the treatment of the symptoms and reversible airflow obstruction associated with chronic asthma and other chronic lung diseases, such as emphysema and chronic bronchitis. Roxane notified FDA by letter dated August 4, 2008, that it was no longer marketing theophylline oral solution, 80 mg/15 mL and requested that ANDA 087449 be withdrawn. Theophylline oral solution, 80 mg/15 mL was moved to the "Discontinued Drug Product List" section of the Orange Book.

Silarx Pharmaceuticals, Inc. (Silarx or petitioner), submitted a citizen petition to FDA dated May 29, 2009 (Docket No. FDA–2009–P–0257), under 21 CFR 10.30, requesting that the Agency accept an ANDA submitted by Silarx for theophylline oral solution 80 mg/15 mL, referencing ANDA 087449 as the listed drug. FDA cannot approve the petitioner's ANDA or any ANDA unless it first determines whether ANDA 087449 was withdrawn from sale for reasons of safety or effectiveness.

After considering the citizen petition and reviewing Agency records, FDA has determined, under § 314.161, that theophylline oral solution, 80 mg/15 mL, ANDA 087449, was not withdrawn from sale for reasons of safety or effectiveness. The petitioner identified no data or other information suggesting that theophylline oral solution, 80 mg/15 mL, was withdrawn from sale for reasons of safety or effectiveness. We have carefully reviewed our files for records concerning the withdrawal of theophylline oral solution, 80 mg/15 mL, from sale. We have also independently evaluated relevant literature and data for possible postmarketing adverse events and have found no information that would indicate that this product was withdrawn from sale for reasons of safety or effectiveness.

Accordingly, the Agency will continue to list theophylline oral solution, 80 mg/15 mL, in the "Discontinued Drug Product List" section of the Orange Book. The "Discontinued Drug Product List" delineates, among other items, drug products that have been discontinued from marketing for reasons other than safety or effectiveness. ANDAs that refer to theophylline oral solution, 80 mg/15 mL, may be approved by the Agency if they meet all other legal and regulatory requirements for the approval of ANDAs. If FDA determines that labeling for this drug product should be revised to meet current standards, the Agency will advise ANDA applicants to submit such labeling.

Dated: February 15, 2011.

Leslie Kux,

Acting Assistant Commissioner for Policy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Office of Urban Indian Health Programs; Announcement Type: Limited Competition, Continuation; Funding Announcement Number: HHS–2011–IHS–UIHP–0001

Catalogue of Federal Domestic Assistance Number: 93.193

Key Dates: Application Deadline Date: March 23, 2011.

Review Period: April 25–27, 2011.

Earliest Anticipated Start Date: May 16, 2011.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS), Office of Urban Indian Health Programs (OUIHP), announces the FY 2011 limited competition, continuation grants for continued operation support for the 4-in-1 Title V grants to make health care services more accessible for American Indians and Alaska Natives (AI/AN) residing in urban areas. This program is authorized under the authority of the Snyder Act, 25 U.S.C. 1652, 1653, 1660a of Title V of the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, as amended.

This program is described at 93.193 in the Catalog of Federal Domestic Assistance (CFDA).

Background

Prior to the 1950s, most AI/ANs resided on reservations, in nearby rural towns, or in Tribal jurisdictional areas such as Oklahoma. In the era of the 1950s and 1960s, the Federal Government passed legislation to terminate its legal obligations to the Indian Tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs (BIA) Relocation/Employment Assistance Programs (BIA Relocation) which enticed Indian families living on impoverished Indian Reservations to "relocate" to various cities across the country, i.e., San Francisco, Los Angeles, Chicago, Salt Lake City, Phoenix, etc. BIA Relocation offered job training and placement, and was viewed by Indians as a way to escape poverty on the reservation. Health care was usually provided for six months through the private sector, unless the family was relocated to a city near a reservation with an IHS facility service area, such as Rapid City, Phoenix, and Albuquerque. Eligibility for IHS was not forfeited due to Federal Government relocation.

The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated over 160,000 AI/ANs to selected urban centers across the country. Today, over 61 percent of all AI/ANs identified in the 2010 census reside off-reservation.

In the late 1960s, urban Indian community leaders began advocating at the local, State and Federal levels for culturally appropriate health programs addressing the unique social, cultural and health needs of AI/ANs residing in urban settings. These community-based grassroots efforts resulted in programs targeting health and outreach services to the urban Indian community. Programs that were developed at that time were in many cases staffed by volunteers, offering outreach and referral-type services, and maintaining programs in storefront settings with limited budgets and primary care services.

In response to efforts of the urban Indian community leaders in the 1960s, Congress appropriated funds in 1966, through the IHS, for a pilot urban clinic in Rapid City. In 1973, Congress appropriated funds to study the unmet urban Indian health needs in Minneapolis. The findings of this study documented cultural, economic, and access barriers to health care and resulted in Congressional appropriations under the Snyder Act to support emerging Urban Indian clinics in several BIA relocation cities, i.e., Seattle, San Francisco, Tulsa, and Dallas.

The awareness of poor health status of all Indian people continued to grow, and in 1976, Congress passed the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, establishing the Urban Indian Health Program under Title V. Congress reauthorized the IHCIA in 2010 under Public Law 111–148 (2010). This law is considered health care reform legislation to improve the health and well-being of all AI/ANs, including urban Indians. Title V specific funding is authorized for the development of programs for AI/ANs residing in urban areas. Since passage of this legislation, amendments to Title V provided resources to and expanded Urban Indian Health Programs in the areas of direct medical services, alcohol services, mental health services, human immunodeficiency virus (HIV) services, and health promotion—disease prevention services.

Purpose

Under this grant opportunity, the IHS proposes to award grants to 34 Urban Indian Health Programs (UIHP), which are Urban Indian organizations that have existing IHS contracts, in accordance with 25 U.S.C. 1653(c)–(e), 1660a. This grant announcement seeks to ensure the highest possible health status for AI/ANs. Funding will be used to continue the 34 urban Indian organizations' successful implementation of the priorities of the Department of Health and Human Services (HHS), Strategic Plan Fiscal Years 2007–2012, Healthy People 2020, and the IHS Strategic Plan 2006–2011. Additionally, funding will be utilized to meet objectives for Government Performance Rating Act (GPRA) reporting, collaborative activities with the Veterans Health Administration (VA), and four health programs that make health services more accessible to AI/ANs living in urban areas. The four health services programs are: (1) Health Promotion/Disease Prevention (HP/DP) services, (2) Immunizations, and Behavioral Health Services consisting of (3) Alcohol/Substance Abuse services, and (4) Mental Health Prevention and Treatment services. These programs are integral components of the IHS improvement in patient care initiative and the strategic objectives focused on improving safety, quality, affordability, and accessibility of health care.

II. Award Information

Type of Awards—Limited Competition, Continuation Grants

Estimated Funds Available—The total amount of funding identified for the current fiscal year (FY) 2011 is approximately $8 million. Competing and continuation awards issued under this announcement are subject to the availability of funds. In the absence of funding, the Agency is under no obligation to make awards funded under this announcement.

Anticipated Number of Awards—Approximately 34 grants will be issued under this program announcement.

Project Period—Five year award. April 1, 2011—March 31, 2016.

Award Amount—$135,289 to $612,893, subject to the availability of congressional appropriations.

III. Eligibility Information

1. Eligibility

Competition is limited to those urban Indian organizations currently contracted under Title V of the IHCIA. It is legislatively mandated that the urban Indian organization must have a Title V contract in place to be eligible to apply for a Title V grant. 25 U.S.C. 1653(c)–(e), 1660a. Urban Indian organizations are defined by 25 U.S.C. 1603(29) as a non-profit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. 1653(a). 25 U.S.C. 1603(29). Each organization must provide proof of non-profit status with the application, including a copy of the 501 (c)(3) Certificate.

2. Cost Sharing or Matching

This program does not require matching funds or cost sharing.

3. Other Requirements

If the application budget exceeds the stated dollar amount that is outlined within this announcement, it will not be considered for funding.

IV. Application and Submission Information

1. Obtaining Application Materials

The Applicant package and instructions may be located at Grants.gov (*http://www.grants.gov*) or at: *http://www.ihs.gov/NonMedicalPrograms/gogp/gogp_funding.asp*.

Information regarding the electronic application process may be directed to Paul Gettys at (301) 443–2114.

2. Content and Form of Application Submission

The application must include the project narrative as an attachment to the application package.

Mandatory documents for all applications include:

- Application forms:
  - SF–424.
  - SF–424A.
  - SF–424B.
- Budget Narrative (must be single spaced).
- Project Narrative (must not exceed twenty-five pages).
- 501(c)(3) Certificate.
- Biographical sketches of all Key Personnel.
- Disclosure of Lobbying Activities (SF–LLL) (if applicable), *http://www.whitehouse.gov/sites/default/files/omb/grants/sflllin.pdf*.
- Documentation of current OMB A–133 required Financial Audits. Acceptable forms of documentation include:
  - E-mail confirmation from the Federal Audit Clearinghouse (FAC) that audits were submitted; or
  - Face sheets from audit reports. These can be found on the FAC Web site: *http://harvester.census.gov/fac/dissem/accessoptions.html?submit=Retrieve+Records*

Public Policy Requirements

All Federal wide public policies apply to IHS grants with exception of the Discrimination policy.

Requirements for Project and Budget Narratives

A. Project Narrative: This narrative should be a separate Word document that is no longer than 25 pages with consecutively numbered pages. Be sure to place all responses and required information in the correct section or they will not be considered or scored. If the narrative exceeds the page limit, only the first 25 pages will be reviewed. The narrative consists of three parts: Part A—Program Information; Part B—Program Planning and Evaluation; and Part C—Program Report. See below for additional details about what must be included in the narrative.

Part A: Program Information
  Section 1: Needs
Part B: Program Planning and Evaluation
  Section 1: Program Plans
  Section 2: Program Evaluation
Part C: Program Report
  Section 1: Describe Major Accomplishments for the Last 9 Months, From April 1, 2010–December 31, 2010
  Section 2: Describe Major Activities Planned for the Next 12 Months, Beginning April 1, 2011

B. Budget Narrative: This narrative must describe the budget requested and match the scope of work described in the project narrative. The page limitation should not exceed three pages.

3. Submission Dates and Times

Applications must be submitted electronically through Grants.gov by March 23, 2011 at 12 midnight Eastern Standard Time (EST). Any application received after the application deadline will not be accepted for processing, and it will be returned to the applicant(s) without further consideration for funding.

If technical challenges arise and the Urban Indian Health Organization (UIHP) is unable to successfully complete the electronic application process, contact Grants.gov Customer Service Support via e-mail to *support@Grants.gov* or phone at (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except Federal holidays). If problems persist, contact Paul Gettys, Division of Grants Management (DGM), *Paul.gettys@ihs.gov* at (301) 443–5204. Please be sure to contact Mr. Gettys at least ten days prior to the application deadline. Please do not contact the DGM until you have received a Grants.gov tracking number. In the event you are not able to obtain a tracking number, call the DGM as soon as possible.

If an applicant needs to submit a paper application instead of submitting electronically via Grants.gov, prior approval must be requested and obtained (see page 11 for additional information). The waiver must be documented in writing (e-mails are acceptable), before submitting a paper application. A copy of the written approval must be submitted along with the hardcopy that is mailed to the DGM (Refer to Section IV to obtain mailing address). Paper applications that are submitted without a waiver will be returned to the applicant without review or further consideration. The application must be postmarked by March 23, 2011. Applications received after this date will not be accepted for processing, will be returned to the applicant, and will not be considered for funding.

4. Intergovernmental Review

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

5. Funding Restrictions

- Pre-award costs are allowable pending prior approval from the awarding agency. However, in accordance with 45 CFR Part 74, all pre-award costs are incurred at the recipient's risk. The awarding office is under no obligation to reimburse such costs if for any reason the UIHOs do not receive an award or if the award to the recipient is less than anticipated;
- The available funds are inclusive of direct and appropriate indirect costs;
- Only one grant/cooperative agreement will be awarded per applicant; and
- IHS will not acknowledge receipt of applications.

6. Electronic Submission Requirements

Use the *http://www.Grants.gov* Web site to submit an application electronically and select the "Find Grant Opportunities" link on the homepage. Download a copy of the application package, complete it offline, and then upload and submit the application via the Grants.gov Web site. Electronic copies of the application may not be submitted as attachments to e-mail messages addressed to IHS employees or offices.

Applicants that receive a waiver to submit paper application documents must follow the rules and timelines that are noted below. The applicant must seek assistance at least ten days prior to the application deadline.

Applicants that do not adhere to the timelines for Central Contractor Registry (CCR) and/or Grants.gov registration and/or request timely assistance with technical issues will not be considered for a waiver to submit a paper application.

Please be aware of the following:

- Please search for the application package in Grants.gov by entering the CFDA number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- Paper applications are not the preferred method for submitting applications. However, if you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: *http://www.Grants.gov/CustomerSupport* or (800) 518–4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).

• Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and waiver from the agency must be obtained.

• If it is determined that a waiver is needed, you must submit a request in writing (e-mails are acceptable) to *GrantsPolicy@ihs.gov* with a copy to *Tammy.Bagley@ihs.gov.* Please include a clear justification for the need to deviate from our standard electronic submission process.

• If the waiver is approved, the application should be sent directly to the DGM with a postmark of no later than March 23, 2011.

Division of Grants Management, Indian Health Service, 801 Thompson Avenue, TMP 360, Rockville, MD 20852.

• Applicants are strongly encouraged not to wait until the deadline date to begin the application process through Grants.gov as the registration process for CCR and Grants.gov could take up to fifteen working days.

• Please use the optional attachment feature in Grants.gov to attach additional documentation that may be requested by the DGM.

• All applicants must comply with any page limitation requirements described in this Funding Announcement.

• After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The DGM will download your application from Grants.gov and provide necessary copies to the appropriate agency officials. Neither the DGM nor the OUIHP will notify applicants that the application has been received.

E-mail applications will not be accepted under this announcement.

Dun and Bradstreet (D&B) Data Universal Numbering Systems (DUNS)

All IHS applicants and grantee organizations are required to obtain a DUNS number and maintain an active registration in the CCR database. Additionally, all IHS grantees must notify potential first-tier sub-recipients that no entity may receive a first-tier sub-award unless the entity has provided its DUNS number to the prime grantee organization. These requirements will ensure use of a universal identifier to enhance the quality of information available to the public when recipients begin on October 1, 2010 to report information on sub-awards, as required by the Federal Funding Accountability and Transparency Act (FFATA) of 2006, as amended ("the Transparency Act"). The DUNS number is a unique nine digit identification number provided by D&B, which uniquely identifies your entity. The DUNS number is site specific; therefore each distinct performance site may be assigned a DUNS number. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, you may access it through the following Web site *http://fedgov.dnb.com/webform* or to expedite the process call (866) 705–5711.

Central Contractor Registry (CCR)

Organizations that have not registered with CCR will need to obtain a DUNS number first and then access the CCR online registration through the CCR home page at *https://www.bpn.gov/ccr/default.aspx* (U.S. organizations will also need to provide an Employer Identification Number from the Internal Revenue Service that may take an additional 2–5 weeks to become active). Completing and submitting the registration takes approximately one hour to finish and your CCR registration will take 3–5 business days to process. Registration with the CCR is free of charge. Applicants may register online at *http://www.ccr.gov.*

Additional information on implementing FFATA, including the specific requirements for—DUNS, CCR, can be found on the IHS Grants Policy Web site: *http://www.ihs.gov/NonMedicalPrograms/gogp/index.cfm?module=gogp_policy_topics*

V. Application Review Information

1. Evaluation Criteria

The instructions for preparing the application narrative also constitute the evaluation criteria for reviewing the application.

The narrative should address program progress for the 12 months continuation budget period activities, April 1, 2011 through March 31, 2012.

The narrative should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the UIHP. It should be well organized, succinct, and contain all information necessary for reviewers to fully understand the project.

Points assigned for the criteria are as follows:

• UNDERSTANDING OF THE NEED AND NECESSARY CAPACITY (30 Points)

• WORK PLANS (40 Points)

• PROJECT EVALUATION (15 Points)

• ORGANIZATIONAL CAPABILITIES AND QUALIFICATIONS (10 Points)

• CATEGORICAL BUDGET AND BUDGET JUSTIFICATION (5 Points)

A. PROJECT NARRATIVE: UNDERSTANDING OF THE NEED AND NECESSARY CAPACITY (30 points)

1. Facility Capability

Urban Indian programs provide health care services within the context of the HHS Strategic Plan, Fiscal Years 2007–2012; the IHS Strategic Plan 2006–2011, and four IHS priorities.

Describe the UIHP: (1) Current budget period performance April 1, 2010–December 31, 2010 accomplishments and (2) define activities planned for the 2011 continuation budget period April 1, 2011–March 31, 2012 budget period in each of the following areas:

a. IHS Priorities for American Indian/Alaska Native Health Care

Current governmental trends and environmental issues impact AI/ANs residing in urban locations and require clear and consistent support by the Title V funded UIHP. The IHS Web site is *http://www.ihs.gov.*

(1) Renew and Strengthen Partnerships with Tribes and the UIHPs: The UIHPs have a hybrid relationship with the IHS. With the passage of Public Law 111–148, the Indian Health Care Improvement Act was made permanent.

• Identify what the UIHP is doing to strengthen its partnerships with Tribes and other UIHPs.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned, including information on how results are shared with the community.

c. List the top ten Tribes who members are seen by the program.

(2) Bring Health Care Reform to the UIHPs: In order to support health care reform, it must be demonstrated there is a willingness to change and improve, i.e., in human resources and business practices.

• Describe activities the UIHP is taking to ensure health care reform is being applied.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

(3) Improve the Quality of and Access to Care: Customer service is the key to quality care. Treating patients well is the first step to improving quality and access. This area also incorporates Best Practices in customer service.

• Identify activities that demonstrate the UIHP improving quality of and access to care.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

(4) Ensure all UIHP work is Transparent, Accountable, Fair, and Inclusive: Quality health care needs to be transparent, with all parties held accountable for that care. Accountability for services is emphasized.

• Describe activities that demonstrate how this is implemented in the UIHP program.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

b. HHS Priorities for Health Care

Current governmental trends and environmental issues impact AI/ANs residing in urban locations and require clear and consistent support by the Title V funded UIHP.

1. Health Care Value Incentives: The growth of health care costs is restrained because consumers know the comparative costs and quality of their health care—and they have a financial incentive to care.

• Identify what the UIHP is doing to help its consumers gain control of their health care and have the knowledge to make informed health care decisions.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned, including information on how clinical quality data is shared with consumers and the community.

2. Health Information Technology: The medical clipboard is becoming a thing of the past. Secure interoperable electronic records are available to patients and their doctors anytime, anywhere.

• Describe activities the UIHP is taking to ensure immediate access to accurate information to reduce dangerous medical errors and help control health care costs.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

3. Medicare Rx: Every senior has access to affordable prescription drugs. Consumers will inspire plans to provide better benefits at lower costs. Medicare Part D is streamlined and improved to better connect people with their benefits. Pay for Performance methodologies act to increase health care quality.

• Identify activities the UIHP is taking to implement Medicare Rx.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

4. Personalized Health Care: Health care is tailored to the individual. Prevention is emphasized. Propensities for disease are identified and addressed through preemptive intervention.

• Describe activities that demonstrate how this is implemented in the UIHP program.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–March 31, 2012 activities planned.

5. Obesity Prevention: The risk of many diseases and health conditions are reduced through actions that prevent obesity. A culture of wellness deters or diminishes debilitating and costly health events. Individual health care is built on a foundation of responsibility for personal wellness.

• Describe activities that demonstrate how the UIHP program is implementing this priority.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–December 31, 2012 activities planned.

6. Tobacco Cessation: The only proven strategies to reduce the risks of tobacco-caused disease are preventing initiation, facilitating cessation, and eliminating exposure to secondhand smoke.

• Describe activities that demonstrate how the UIHP is implementing this priority.

a. April 1, 2010–December 31, 2010 accomplishments.

b. April 1, 2011–December 31, 2012 activities planned.

7. Pandemic Preparedness: The United States is better prepared for an influenza pandemic. Rapid vaccine production capacity is increased, national stockpiles and distribution systems are in place, disease monitoring and communication systems are expanded and local preparedness encompasses all levels of government and society.

• Describe activities that demonstrate how the UIHP is prepared and identify changes, if any, made to the UIHP pandemic preparedness plan.

8. Emergency Response: We have learned from the past and are better prepared for the future. There is an ethic of preparedness at the urban program and throughout the Nation.

• Describe activities that demonstrate how the UIHP is prepared and identify changes, if any, made to the UIHP emergency preparedness plan.

9. Hours of Operation Ensure Access to Care

• Identify the urban program hours of operation and provide assurance that services are available and accessible at times that meet the needs of the urban Indian population, including arrangements that assure access to care when the UIHP is closed.

c. UIHP Collaboration With the Veteran's Health Administration (VA)

In 2007, the UIHPs contacted their local VA Veterans Integrated Services Network and established agreements to collaborate at the local level to expand opportunities to enhance access to health services and improve the quality of health care of AI/AN veterans.

1. Report April 1, 2010–December 31, 2010 results/outcomes of the collaborative activities implemented or explored between your UIHP and your local area VA. Include number of patients who used VA services, number of visits made, and types of healthcare services provided.

2. Identify areas of collaboration and activities that will be conducted between your UIHP and your local area VA for continuation budget period April 1, 2011–March 31, 2012.

d. GPRA Reporting

All UIHPs report on IHS GPRA clinical performance measures. This is required of both urban facilities using the Resource and Patient Management System (RPMS) and facilities not using RPMS. RPMS users must use the Clinical Reporting System (CRS) for reporting, and non-RPMS users must develop a bridge to transfer data from their current data system to RPMS for CRS reporting. Questions related to GPRA reporting may be directed to the IHS Area Office GPRA Coordinator, or Danielle Steward, Health Systems Specialist, OUIHP, *danielle.steward@ihs.gov*

The 2012 GPRA Report Period is July 1, 2011 through June 30, 2012. The GPRA measures to report for 2012 will include the 20 GPRA measures reported for 2010.

Note that the target rates for FY 2011 GPRA are not currently available. They will be provided in calendar year 2011.

1. During the continuation budget period, April 1, 2011–March 31, 2012, the following GPRA measures are priority focus areas for target achievement: (#1) Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c < 7.0) achieve 2011 and 2012 target rates. (#4) Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (< 130/80) achieve 2011 and 2012 target rates. (#9) Cancer Screening: Colorectal Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening.

Briefly describe the steps/activities you will take to ensure your program meets the 2011 target rates for these measures.

2. Significant increases to the measurement targets of (#16) Domestic Violence/Intimate Partner Violence Screening, (#17) Depression Screening, and (#12) Mammography Screening will occur in the 2011 GPRA year. Describe at least two actions you will complete to meet the 2011 desired performance outcomes/results. For programs using RPMS, a Performance Improvement Toolbox is available on the CRS Web site at *http://www.ihs.gov/cio/crs_performance_improvementtoolbox.asp*

3. GPRA Behavioral Health performance measures include alcohol screening, Fetal Alcohol Syndrome (FAS) prevention, domestic (intimate partner) violence screening, depression screening, HIV/AIDS screening and suicide surveillance. Describe actions you will take to improve 2011–2012 desired behavioral health performance outcomes/results.

4. Document your ability to collect and report on the required performance measures to meet GPRA requirements. Include information about your health information technology system.

FY 2011 GPRA Measures

1. Diabetes DX Ever (not a GPRA measure, used for context only).
2. Documented A1c (not a GPRA measure, used for context only).
3. Poor Glycemic Control.
4. Ideal Glycemic Control.
5. Controlled Blood Pressure.
6. Dyslipidemia (LDL) Assessment.
7. Nephropathy Assessment.
8. Influenza 65 years old +.
9. Pneumovax 65 years old +.
10. Childhood Immunizations.
11. Pap Smear Rates.
12. Mammography Rates.
13. Colorectal Cancer Rates.
14. Tobacco Cessation.
15. Alcohol Screening (FAS Prevention).
16. Domestic Violence/Intimate Partner Violence Screening.
17. Depression Screening.
18. Prenatal HIV Screening.
19. Childhood Weight Control.
20. Suicide Surveillance.

e. Schedule of Charges and Maximization of Third Party Payments

1. Describe the UIHP established schedule of charges and consistency with local prevailing rates.

• If the UIHP is not currently billing for billable services, describe the process the UIHP will take to begin third party billing to maximize collections.

2. Describe how reimbursement is maximized from Medicare, Medicaid, State Children's Health Insurance Program, private insurance, etc.

3. Describe how the UIHP achieves cost effectiveness in its billing operations with a brief description of the following:

a. Establishes appropriate eligibility determination.

b. Reviews/updates and implements up-to-date billing and collection practices.

c. Updates insurance at every visit.

d. Maintains procedures to evaluate necessity of services.

e. Identifies and describes financial information systems used to track, analyze and report on the program's financial status by revenue generation, by source, aged accounts receivable, provider productivity, and encounters by payor category.

f. Indicates the date the UIHP last reviewed and updated its Billing Policies and Procedures.

B. Program Planning: Work Plans (40 Points)

A program narrative and a program specific work plan are required for each health services program: (1) Health Promotion/Disease Prevention, (2) Immunizations, (3) Alcohol/Substance Abuse, and (4) Mental Health. Title V of the IHCIA, Public Law 94–437, as amended, identifies eligibility for health services as follows.

Each grantee shall provide health care services to eligible Urban Indians living within the urban service area. An "Urban Indian" eligible for services, as codified at 25 U.S.C. 1603(13), (27), (28), includes any individual who:

(1) Resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary, HHS; and who

(2) Meets one or more of the following criteria:

(A) Irrespective of whether he or she lives on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including: (i) Those Tribes, bands, or groups terminated since 1940, and (ii) those recognized now or in the future by the State in which they reside; or

(B) Is a descendant, in the first or second degree, of any such member described in (A); or

(C) Is an Eskimo or Aleut or other Alaska Native; or

(D) Is the descendant of an Indian who was residing in the State of California on June 1, 1852, so long as the descendant is now living in said State; or [1]

(E) Is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or

(F) Is determined to be an Indian under regulations pertaining to the Urban Indian Health Program that are promulgated by the Secretary, HHS.

[1] Eligibility of California Indians may be demonstrated by documentation that the individual:

(1) Holds trust interests in public domain, national forest, or Indian reservation allotments; or

(2) Is listed on the plans for distribution of assets of California Rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or is the descendant of such an individual.

Each grantee is responsible for taking reasonable steps to confirm that the individual is eligible for IHS services as an urban Indian.

Program Narratives and Workplans

(1) HP/DP

Program Narrative and Work Plan

Contact your IHS Area Office HP/DP Coordinator to discuss and identify effective and innovative strategies to promote health and enhance prevention efforts to address chronic diseases and conditions. Identify one or more of the strategies you will conduct during budget period April 1, 2011—March 31, 2012.

1. Applicants are encouraged to use evidence-based and promising strategies which can be found at the IHS best practice database at *http://www.ihs.gov/hpdp*/and the National Registry for Effective Programs at *http://modelprograms.samhsa.gov/*

2. Program Narrative. Provide a brief description of the collaboration activities that: (1) Were accomplished April 1, 2010–December 31, 2010, and (2) are planned and will be conducted between your UIHP and the IHS Area Office HP/DP Coordinator during the budget period April 1, 2011 through March 31, 2012.

3. An example of an HP/DP work plan is provided on the following pages. Develop and attach a copy of the UIHP HP/DP Work Plan for April 1, 2011 through March 31, 2012.

SAMPLE 2011 HP/DP WORK PLAN

Objectives	Activities/time line	Person responsible	Evaluation
Goal: To address physical inactivity and consumption of unhealthy food among youth who are in the 4th to 6th grade in the Watson, Kennedy, Blackwood, and Rocky Hill Elementary schools.			
1. Develop school policies to address physical inactivity and consumption of unhealthy foods in the first year of the funding year.	1. Schedule a meeting with the school health board in the first quarter of the project. 2. Establish a parent advisory committee to assist with the development of the policy in 2nd quarter.	Program Coordinator ..... School Administrator	Progress report on status of policy and documentation of number of participants in parent advisory committee, and number of meetings held.
2. Implement a classroom nutrition curriculum to increase awareness about the importance of healthier foods.	1. Design pre/post test survey and pilot test with group of students by 2nd quarter.	Program Coordinator ..... IHS Nutritionist	Pre/post knowledge, attitude, and behavior survey.
	2. Schedule a meeting with the School Principal to discuss dates of program implementation by 3rd quarter.	.....	
	3. Implement the "Healthy Eating" curriculum, a 6-week program in the 2nd quarter.	.....	
	4. Collect pre/post survey at beginning and end of the program to assess changes.	.....	
3. Implement physical activity in at least four schools for grades 4th to 6th in first year of the funding.	1. Contract with SPARK PE to train classroom teachers to implement SPARK PE in the school by 3rd Quarter.	Program Coordinator ..... School Counselor and PE teacher.	1. Training evaluation and number of participants.
	2. Train volunteers to administer FITNESSGRAM to collect baseline data and post data to assess changes.	.....	2. Pre/post FITNESSGRAM Data.
Goal: To reduce tobacco use among residents of community X and Y.			
1. Establish a tobacco-free policy in the schools and Tribal buildings by year 1.	1. Schedule a meeting with the Tribal Council and school board to increase awareness of the health effects of tobacco by June 2010.	Tobacco Coordinator	Documentation of the number of participants.
	2. Schedule and conduct tobacco awareness education in the community, schools, and worksites by July 2010 through September 2010.	Tobacco Coordinator ..... Health Educator	Documentation of the number of participants.
	3. Draft a policy and present to the Tribal Council for approval by January 2011.	.....	Documentation of whether the policy was established.
2. Coordinate and establish tobacco cessation programs with the local hospitals and clinics.	1. Partner with the American Cancer Association and the Tribal Health Education Coordinators to establish 8-week tobacco cessation programs by July 2010.	Tobacco Coordinator ..... Health Educator ..... Pharmacist	Progress toward timeline.
	2. Meet with the hospital/clinic administrators and pharmacist to discuss and develop a behavior-based tobacco cessation program.	Tobacco Coordinator ..... Health Educator	Progress report indicating timeline is being met.
	3. Design and disseminate brochures and flyers of the tobacco cessation programs that are available in the community and clinic.	Tobacco Coordinator	Number of brochures distributed.
	4. Meet with nursing and medical provider staff to increase patient referral to tobacco cessation program.	Health Educator Tobacco Coordinator	
	5. Implement the 8-week tobacco cessation program at the community X and Y clinic.	Tobacco Coordinator	RPMS data—baseline # of referrals, # of participants who completed program, # who quit tobacco.

(2) Immunization Services

Program Narrative and Work Plan

1. Program Management Required Activities.

A. Provide assurance that your facility is participating in the Vaccines for Children program.

B. Provide assurance that your facility has look up capability with State/regional immunization registry (where applicable). Please contact Amy Groom, Immunization Program Manager at *amy.groom@ihs.gov* or (505) 248–4374 for more information.

2. Service Delivery Required Activities—For Sites using RPMS.

A. Provide trainings to providers and data entry clerks on the RPMS Immunization package.

B. Establish process for immunization data entry into RPMS (e.g., point of service or through regular data entry).

C. Utilize RPMS Immunization package to identify 3–27 month old children who are not up to date and generate reminder/recall letters.

3. Immunization Coverage Assessment Required Activities.

A. Submit quarterly immunization reports to Area Immunization Coordinator for the 3–27 month old, Two year old and Adolescent and influenza reports. Sites not using the RPMS Immunization package should submit a Two Year old immunization coverage report—an Excel spreadsheet with the required data elements that can be found under the "Report Forms for non-RPMS sites" section at: *http://www.ihs.gov/Epi/index.cfm?module=epi_vaccine_reports*.

4. Program Evaluation Required Activities.

A. Establish baseline for coverage with the 431331* and 4313314** vaccine series for children 19–35 months old.

B. Establish baseline for coverage with influenza vaccine for adults 65 years and older.

C. Establish baseline for coverage with at least one dose of pneumococcal vaccine for adults 65 years and older.

D. Establish baseline coverage for patients (all ages) who received at least one dose of seasonal flu vaccine during flu season.

* The 4:3:1:3:3:1 vaccine series is defined as: = 4 doses diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, or diphtheria and tetanus toxoids and any pertussis vaccine, = 3 doses of oral or inactivated polio vaccine, = 1 dose of measles, mumps, and rubella vaccine, = 3 doses of *Haemophilus influenzae* type b vaccine, = 3 doses of hepatitis B vaccine, and, = 1 of varicella vaccine.

** The 4:3:1:3:3:1:4 vaccine series includes the 4:3:1:3:3:1 series outlined above, +4 or more doses of pneumococcal conjugate vaccine (PCV).

SAMPLE URBAN GRANT FY 2012 WORK PLAN IMMUNIZATION

Primary prevention objective	Service or program	Target population	Process measure	Outcome measures
Protect children and communities from vaccine preventable diseases.	Immunization program.	Children <3 years.	On a quarterly basis: # of children 3–27 months old. # of children 3–27 months old who are children up to date with age appropriate vaccinations. % of 3–27 month old children up to date with age appropriate vaccinations. # of children 19–35 months old. # of children 19–35 months old who received the 431331 and 4313314 vaccine series. # of children 19–35 months old who received the 431331 and 4313314 vaccine series.	As of June 30th 2012: % of 19–35 month olds up to date with the 431331 and 4313314 vaccine series.
Protect adolescents and communities from vaccine preventable diseases.	Immunization program.	Adolescents 13–17 years.	On a quarterly basis: # of adolescents 13–17 years old. # of adolescents 13–17 years old who are up to date with Tdap, Tdap/Td, Meningococcal, and 1, 2 and 3 dose of HPV (females only). % of adolescents 13–17 years old who are up to date with Tdap, Tdap/Td, Meningococcal, and 1, 2 and 3 dose of HPV (females only).	As of June 30th 2012: % of adolescents 13–17 years old who are up to date with Tdap. % of adolescents 13–17 years old who are up to date with Tdap, females only. # of adolescents 13–17 years old who are up to date with Meningococcal vaccine. # of adolescents 13–17 years old who are up to date with 1, 2 and 3 dose of HPV (females only).
Protect adults and communities from influenza.	Immunization program.	All ages	On a quarterly basis during flu season (e.g., Sept–June) # of patients (all ages). # of patients who received a seasonal flu shot during the flu season.	As of June 30th, 2012: # of patients who received a seasonal flu shot during the flu season.

SAMPLE URBAN GRANT FY 2012 WORK PLAN IMMUNIZATION—Continued

Primary prevention objective	Service or program	Target population	Process measure	Outcome measures
			% of patients who received a seasonal flu shot during flu season.	% of patients who received a seasonal flu shot during the flu season.
Protect adults and communities from influenza & Pneumovax.	Immunization program.	Adults >65 years.	On a quarterly basis: # of adults 65+ years.	As of June 30th, 2012:
			# of adults 65+ years who received an influenza shot during flu season. # of adults 65+ years who received a pneumovax shot.	% of adults 65+ years who received an influenza shot Sept. 1, 2010–June 30, 2011.
			% of adults 65+ years who received an influenza shot during flu season. % of adults 65+ years who received a pneumovax shot..	% of adults 65+ years who received a pneumovax shot ever

(3) Alcohol/Substance Abuse

Program Narrative and Work Plan

1. Program Progress Report or Results/Outcomes for April 1, 2010–December 31, 2010.

A. Briefly address the extent to which the program was able to achieve its objectives and demonstrate effective use of funding for April 1, 2010–December 31, 2010.

B. Include quantifiable and qualitative information and describe the relationship to the UDS data submitted for calendar year 2009.

C. Identify Specific Program Services Outcomes/Results:

- State the number of patient encounters (or specific service) per provider staff for this program service,
- List populations and age groups that were targeted (homeless, women, youth, elders, men, etc.), and
- Identify specific outcomes/results that were measured in addition to the number of patient encounters/staff (and not included in the UDS).

2. Narrative Description of Program Services for April 1, 2011–March 31, 2012 Continuation Budget Period.

A. Program Objectives

1. Clearly state the outcomes of the health service.

2. Define needs related outcomes of the program health care service.

3. Define who is going to do what, when, how much, and how you will measure it.

4. Define the population to be served and provide specific numbers regarding the number of eligible clients for whom services will be provided.

5. State the time by which the objectives will be met.

6. Describe objectives in numerical terms—specify the number of clients that will receive services.

7. Describe how achievement of the goals will produce meaningful and relevant results (e.g., increase access, availability, prevention, outreach, pre-services, treatment, and/or intervention).

8. Provide a one-year work plan that will include the primary objectives, services or program, target population, process measures, outcome measures, and data source for measures (*see* work plan sample in Appendix 2).

a. Identify Services Provided: Primary Residential; Detox; Halfway House; Counseling; Outreach and Referral; and Other (Specify).

b. Number of beds: Residential __, Detox__; or Halfway House __.

c. Average monthly utilization for the past year.

d. Identify Program Type: Integrated Behavioral Health; Alcohol and Substance Abuse only; Stand Alone; or part of a health center or medical establishment.

9. Address methamphetamine-related contacts:

a. Identify the documented number of patient contacts during the April 1, 2010–December 31, 2010 budget period, and estimate the number patient contacts during the continuation budget period, April 1, 2011–March 31, 2012.

b. Describe your formal methamphetamine prevention and education program efforts to reduce the prevalence of methamphetamine abuse related problems through increased outreach, education, prevention and treatment of methamphetamine-related issues.

c. Describe collaborative programming with other agencies to coordinate medical, social, educational, and legal efforts.

B. Program Activities

1. Clearly describe the program activities or steps that will be taken to achieve the desired outcomes/results. Describe who will provide (program, staff) what services (modality, type, intensity, duration), to whom (individual characteristics), and in what context (system, community).

2. State reasons for selection of activities.

3. Describe sequence of activities.

4. Describe program staffing in relation to number of clients to be served.

5. Identify number of Full Time Equivalents (FTEs) proposed and adequacy of this number:

- Percentage of FTEs funded by IHS grant funding; and
- Describe clients and client selection.

6. Address the comprehensive nature of services offered in this program service area.

7. Describe and support any unusual features of the program services, or extraordinary social and community involvement.

8. Present a reasonable scope of activities that can be accomplished within the time allotted for program and program resources.

C. Accreditation and Practice Model

- Name of Program Accreditation
- Type of evidence-based practice
- Type of practice-based model

D. Attach the Alcohol/Substance Abuse Work Plan.

IHS Urban Grant FY 2011 Work Plan

ALCOHOL/SUBSTANCE ABUSE PROGRAM SAMPLE WORK PLAN

Objectives	Service or program	Target population	Process measure	Outcome measures	Data source for measures
What are you trying to accomplish?	What type of program do you propose?	Who do you hope to serve in your program?	What information will you collect about the program activities?	What information will you collect to find out the results of your program?	Where will you find the information you collect?
To prevent substance abuse among urban American Indian youth.	Community-based substance abuse prevention curriculum.	American Indian youth ages 5–18 years old.	# of youth completing the curriculum, # of sessions conducted, # of staff trained.	Incidence/prevalence of substance abuse/dependence.	Medical records, RPMS behavioral health package, National Youth Survey.
To prevent substance abuse and related problems.	Afterschool, summer, and weekend activities (e.g. outdoor experiential activities, camps, classroom based problem solving activities).	American Indian youth ages 5–14 years old.	# of youth completing community-based sessions, # of parents completing community- based sessions, # of community-based sessions.	Incidence of substance abuse, incidence of negative and positive attitudes and behaviors, incidence of peer drug use.	Charts, RPMS behavioral health package, National Youth Survey.
Reduce drug use and increase treatment retention.	Matrix model for outpatient treatment.	American Indian adult methamphetamine clients.	# of clients completing program, # of relapse prevention sessions, # of family and group therapies, # of drug education sessions, # of self-help groups, # of urine tests.	Incidence of drug use, increase or decrease in treatment retention, positive or negative urine samples.	Medical records, RPMS behavioral health package, Addiction Severity Index, results of urine tests.

(4) MENTAL HEALTH SERVICES

Program Narrative and Work Plan

Use the alcohol/substance abuse program narrative description template to develop the Mental Health Services program narrative. Attach the UIHP Mental Health Services Work Plan.

IHS Urban Grant FY 2011 Work Plan

MENTAL HEALTH PROGRAM SAMPLE WORK PLAN

Objectives	Service or program	Target population	Process measure	Outcome measures	Data source for measures
What are you trying to accomplish?	What type of program do you propose?	Who do you hope to serve in your program?	What information will you collect about the program activities?	What information will you collect to find out the results of your program?	Where will you find the information you collect?
To promote mental health.	American Indian Life Skills Development curriculum.	American Indian youth ages 13–17 years old.	# of youth completing the curriculum, # of sessions conducted, # of teachers trained, number of community resource leaders trained.	Feelings of hopelessness, problem solving skills.	Medical records, RPMS behavioral health package, Beck Hopelessness Scale, problem solving skills.
Improve the mental health of American Indian children and their families.	Home-based, community-based, and office-based mental health counseling.	American Indian children and their families needing services from our community-based program.	# of individual, couples, group, and family counseling sessions, # of home, community, and office-based visits.	Reduced child involvement in juvenile justice and child welfare, improved coping skills, improved school attendance and grades.	Medical records, RPMS behavioral health package coping skill measure, report cards, attendance records.
Reduce symptoms related to trauma.	Mental health counseling with cognitive behavioral therapy intervention and historical trauma intervention.	American Indian adults.	# of individual, couples, group, and family counseling sessions, # of historical trauma groups, # of adults counseled.	Incidence of Post-Traumatic Stress Disorder (PTSD) symptoms, incidence of depression, increased coping skills, increased peer and family support.	Self-report PTSD, Beck Depression Inventory, coping skills measure, peer and family support measure, medical records, RPMS behavioral health package.

RPMS Suicide Reporting Form

Instructions for Completing

This form is intended as a data collection tool only. It does not replace documentation of clinical care in the medical record and it is not a referral form. The provider should complete a corresponding RPMS Patient Care Components (PCC) or MH/SS encounter form and update the PCC and/or BH problem lists accordingly. Health Record Number, Date of Act and Provider Name are required fields. If the information requested is not known or not listed as an option, choose "Unknown" or "Other" (with specification) as appropriate.

LOCAL CASE NUMBER:
Indicate internal tracking number if used, not required.

DATE FORM COMPLETED:
Indicate the date the Suicide Reporting Form was completed.

PROVIDER NAME:
Record the name of Provider completing the form.

DATE OF ACT:
Record Date of Act as mm/dd/yy. If exact day is unknown, use the month, 1st day of the month (or another default day), year. If exact date of act is unknown, all providers should use the same default day of the month.

HEALTH RECORD NUMBER:
Record the patient's health record number.

DOB/AGE:
Record Date of Birth as mm/dd/yy and patient's age.

SEX:
Indicate Male or Female.

COMMUNITY WHERE ACT OCCURRED:
Record the community code or the name, county and state of the community where the act occurred.

EMPLOYMENT STATUS:
Indicate patient's employment status, choose one.

RELATIONSHIP STATUS:
Indicate patient's relationship status, choose one.

EDUCATION:
Select the highest level of education attained and if less than a High School graduate, record the highest grade completed. Choose one.

SUICIDAL BEHAVIOR:
Identify the self destructive act, choose one. Generally, the threshold for reporting should be ideation with intent and plan, or other acts with higher severity, either attempted or completed.

LOCATION OF ACT:
Indicate location of act, choose one.

PREVIOUS ATTEMPTS:
Indicate number of previous suicide attempts, choose one.

METHOD:
Indicate method used. Multiple entries are allowed, check all that apply. Describe methods not listed.

SUBSTANCE USE INVOLVED:
If known, indicate which substances the patient was under the influence of at the time of the act. Multiple entries allowed, check all that apply. List drugs not shown.

CONTRIBUTING FACTORS:
Multiple entries allowed, check all that apply. List contributing factors not shown.

LETHALITY:
Indicate the level of risk (based on type and location of act, previous number of attempts, method, substance use involved, contributing factors and other clinically relevant information), choose one.

DISPOSITION:
Indicate the type of follow-up planned, if known.

NARRATIVE:
Record any other relevant clinical information not included above.

Note: This document should be shredded after electronic entry into RPMS. updated: 07/16/07

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RPMS Suicide Reporting Form

Local Case Number:		**Health Record Number:**	
Date Form Completed:		**DOB/Age:**	
Provider Name:		**Sex (M/F):**	
Date of Act:		**Community Where Act Occurred:**	

✓	Employment Status	✓	Relationship Status	✓	Education
	Part-time		Single		High School Graduate/GED
	Full-time		Married		Less than High School, highest grade completed:
	Self-employed		Divorced/Separated		Some College/Technical
	Unemployed		Widowed		College Graduate
	Student		Cohabitating/Common-Law		Post Graduate
	Student and employed		Same Sex Partnership		Unknown
	Retired		Unknown		
	Unknown				

✓	Suicidal Behavior	✓	Location of Act	✓	Previous Attempts
	Ideation with Plan and Intent		Home or Vicinity		0
	Attempt		School		1
	Completed Suicide		Work		2
	Attempted suicide w/ Homicide		Jail/Prison/Detention		3 or more
	Completed suicide w/ Homicide		Treatment Facility		Unknown
			Medical Facility		
			Unknown		
			Other *(specify):*		

Method (✓ all that apply)

	Gunshot		***Overdose list:***		Non-prescribed opiates (e.g. Heroin)
	Hanging		Aspirin/Aspirin-like medication		Sedatives/Benzodiazepines/Barbiturates
	Motor Vehicle		Acetaminophen (e.g. Tylenol)		Alcohol
	Jumping		Tricyclic Antidepressant (TCA)		Other Prescription Medication (*specify*):
	Stabbing/Laceration		Other Antidepressant (*specify*):		
	Carbon Monoxide				Other Over-the-counter Medication (*specify*):
	Overdosed Using (select from list)				
	Unknown		Amphetamine/Stimulant		Other (*specify*):
	Other (*specify*):		Prescribed Opiates (e.g. Narcotics)		

Substances Involved (✓ all that apply)

	None		Alcohol		Inhalants
	Alcohol & Other Drugs (select from list)		Amphetamine/Stimulant		Non-Prescribed Opiates (e.g. Heroin)
	Unknown		Cannabis (Marijuana)		Prescribed Opiates (e.g. Narcotics)
			Cocaine		Sedatives/Benzodiazepines/Barbiturates
			Hallucinogens		Other *(specify):*

Contributing Factors (✓ all that apply)

	Suicide of Friend or Relative		History of Substance Abuse/Dependency		Divorce/Separation/Break-up
	Death of Friend or Relative		Financial Stress		Legal
	Victim of Abuse (Current)		History of Mental Illness		Unknown
	Victim of Abuse (Past)		History of Physical Illness		Other (*specify*):
	Occupational/Educational Problem				

✓	Lethality	✓	Disposition		Narrative
	Low		Mental Health (MH) Follow-up		
	Medium		Alcohol/Substance Abuse Follow-up		
	High		Inpatient MH Treatment Voluntary		
			Inpatient MH Treatment Involuntary		
			Medical Treatment (ED or In-patient)		
			Outreach to Family/School/Community		
			Unknown		
			Other (specify):		

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C. PROJECT EVALUATION (15 Points)

1. Describe your evaluation plan. Provide a plan to determine the degree to which objectives are met and methods are followed.

2. Describe how you will link program performance/services to budget expenditures. Include a discussion of UDS and GPRA Report Measures here.

3. Include the following program specific information:

a. Describe the expected feasibility and reasonable outcomes (e.g., decreased drug use in those patients receiving services) and the means by which you determined these targets or results.

b. Identify dates of reviews by the internal staff to assess efficacy:

I. Assessment of staff adequacy.
II. Assessment of current position descriptions.
III. Assessment of impact on local community.
IV. Involvement of local community.
V. Adequacy of community/governance board.
VI. Ability to leverage IHS funding to obtain additional funding.
VII. Additional IHS grants obtained.
VIII. New initiatives planned for funding year.
IX. Customer satisfaction evaluations.

4. Quality Improvement Committee (QIC).

The UIHP QIC, a planned, organization-wide, interdisciplinary team, systematically improves program performance as a result of its findings regarding clinical, administrative and cost-of-care performance issues, and actual patient care outcomes including the GPRA and UDS reports (results of care including safety of patients).

a. Identify the QIC membership, roles, functions, and frequency of meetings. Frequency of meeting shall be at least quarterly.

b. Describe how the results of the QIC reviews provide regular feedback to the program and community/governance board to improve services.

1. April 1, 2010–December 31, 2010 accomplishments.

2. April 1, 2011–March 31, 2012 activities planned.

c. Describe how your facility is integrating the care model into your health delivery structure:

1. Identify specific measures you are tracking as part of the Improvements in Patient Care (IPC) work.

2. Identify community members that are part of your IPC team.

3. Describe progress meeting your program's goals for the use of the IPC model within your healthcare delivery model.

D. Progress Report: Organizational Capabilities and Qualifications (10 Points)

This section outlines the broader capacity of the organization to complete the project outlined in the continuation application and program specific work plans. This section includes the identification of personnel responsible for completing tasks and the chain of responsibility for successful completion of the project outlined in the work plans.

1. Describe the organizational structure with a current approved one page organizational chart that shows the board of directors, key personnel, and staffing. Key positions include the Chief Executive Officer or Executive Director, Chief Financial Officer, Medical Director, and Information Officer.

2. Describe the board of directors that is fully and legally responsible for operation and performance of the 501(c)(3) non-profit urban Indian organization:

a. List all current board members by name, sex, and Tribe or race/ethnicity.

b. Indicate their board office held.

c. Indicate their occupation or area of expertise.

d. Indicate if the board member uses the UIHP services.

e. Indicate if the board member lives in the health service area.

f. Indicate the number of years of continuous service.

g. Indicate number of hours of Board of Directors training provided, training dates and attach a copy of the Board of Directors training curriculum.

3. List key personnel who will work on the project.

a. Identify existing key personnel and new program staff to be hired.

b. For all new key personnel only include position descriptions and resumes in the appendix. Position descriptions should clearly describe each position and duties indicating desired qualifications, experience, and requirements related to the proposed project and how they will be supervised. Resumes must indicate that the proposed staff member is qualified to carry out the proposed project activities and who will determine if the work of a contractor is acceptable.

c. Identify who will be writing the progress reports.

d. Indicate the percentage of time to be allocated to this project and identify the resources used to fund the remainder of the individual's salary if personnel are to be only partially funded by this grant.

E. Categorical Budget and Budget Justification (5 Points)

This section should provide a clear estimate of the project program costs and justification for expenses for the continuation budget period April 1, 2011–March 31, 2012. The budget and budget justification should be consistent with the tasks identified in the work plan.

1. Categorical Budget (Form SF 424A, Budget Information Non-Construction Programs) complete each of the budget periods requested.

a. Provide a narrative justification for all costs, explaining why each line item is necessary or relevant to the proposed project. Include sufficient details to facilitate the determination of cost allowability.

b. If indirect costs are claimed, indicate and apply the current negotiated rate to the budget. Include a copy of the current rate agreement in the appendix.

2. Review and Selection

Each application will be prescreened by the DGM staff for eligibility and completeness as outlined in the funding announcement. Incomplete applications and applications that are non-responsive to the eligibility criteria will not be referred to the Objective Review Committee. Applicants will be notified by DGM, via letter, to outline the missing components of the application.

To obtain a minimum score for funding by the Objective Review Committee, applicants must address all program requirements and provide all required documentation. Applicants that receive less than a minimum score will be considered to be "Disapproved" and will be informed via e-mail or regular mail by the IHS Program Office of their application's deficiencies. A summary statement outlining the strengths and weaknesses of the application will be provided to each disapproved applicant. The summary statement will be sent to the Authorized Organizational Representative (AOR) that is identified on the face page of the application within 60 days of the completion of the Objective Review.

VI. Award Administration Information

1. Award Notices

The Notice of Award (NoA) will be initiated by DGM and will be mailed via postal mail to each entity that is approved for funding under this announcement. The NoA will be signed by the Grants Management Officer and this is the authorizing document for which funds are dispersed to the approved entities. The NoA will serve as the official notification of the grant award and will reflect the amount of Federal funds awarded, the purpose of the grant, the terms and conditions of the award, the effective date of the award, and the budget/project period. The NoA is the legally binding document and is signed by an authorized grants official within the IHS.

2. Administrative Requirements

Grants are administered in accordance with the following regulations, policies, and OMB cost principles:

A. The criteria as outlined in this Program Announcement.

B. Administrative Regulations for Grants:

- 45 CFR Part 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments.
- 45 CFR Part 74, Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and other Non-profit Organizations.

C. Grants Policy:

- HHS Grants Policy Statement, Revised 01/07.

D. Cost Principles:

- Title 2: Grant and Agreements, Part 225—Cost Principles for State, Local, and Indian Tribal Governments (OMB A–87).
- Title 2: Grant and Agreements, Part 230—Cost Principles for Non-Profit Organizations (OMB Circular A–122).

E. Audit Requirements:

- OMB Circular A–133, Audits of States, Local Governments, and Non-profit Organizations.

3. Indirect Costs

This section applies to all grant recipients that request reimbursement of indirect costs in their grant application. In accordance with HHS Grants Policy Statement, Part II–27, IHS requires applicants to obtain a current indirect cost rate agreement prior to award. The rate agreement must be prepared in accordance with the applicable cost principles and guidance as provided by the cognizant agency or office. A current rate covers the applicable grant activities under the current award's budget period. If the current rate is not on file with the DGM at the time of award, the indirect cost portion of the budget will be restricted. The restrictions remain in place until the current rate is provided to the DGM. Generally, indirect costs rates for IHS grantees are negotiated with the Division of Cost Allocation *http://rates.psc.gov/* and the Department of Interior (National Business Center) *http://www.aqd.nbc.gov/services/ICS.aspx*. If your organization has questions regarding the indirect cost policy, please call (301) 443–5204 to request assistance.

4. Reporting Requirements

Failure to submit required reports within the time allowed may result in suspension or termination of an active agreement, withholding of additional awards for the project, or other enforcement actions such as withholding of payments or converting to the reimbursement method of payment. Continued failure to submit required reports may result in one or both of the following: (1) The imposition of special award provisions; and (2) the non-funding or non-award of other eligible projects or activities. This applies whether the delinquency is attributable to the failure of the organization or the individual responsible for preparation of the reports.

The reporting requirements for this program are noted below:

A. Program Progress Report

Program progress reports are required quarterly. These reports will include a brief comparison of actual program accomplishments to the goals established for the period, reasons for slippage (if applicable), and other pertinent information as required. A final program report must be submitted within 90 days of expiration of the budget/project period.

B. Financial Status Report

A quarterly financial status report must be submitted within 30 days of the end of the half year. A final financial status report is due within 90 days of expiration of the budget period. Standard Form 269 (long form) will be used for financial reporting.

C. Annual Audit Report

The reports and records of the urban Indian organization with respect to a contract or grant under Subchapter IV, 25 U.S.C. 1657 shall be subject to audit by the Secretary and the Comptroller General of the United States.

The Secretary shall allow as a cost to any contract or grant entered into under section 1653 of this title the cost of an annual private audit conducted by a certified public accountant.

D. GPRA Report

GPRA reports are required quarterly. These reports are submitted to the IHS Area GPRA Coordinator. RPMS users must use CRS for reporting. Non-RPMS users must use the interface system to transfer data from their current data system to RPMS for CRS reporting.

E. Quarterly Immunization Report

Immunization reports are required quarterly. These reports are submitted to the IHS Area Immunization Coordinator.

F. Federal Cash Transaction Reports

Federal Cash Transaction Reports are due every calendar quarter to the Division of Payment Management, Payment Management Branch, HHS at: *http://www.dpm.gov.* Failure to submit timely reports may cause a disruption in timely payments to your organization.

Grantees are responsible and accountable for accurate reporting of the Progress Reports and Financial Status Reports which are generally due annually. Financial Status Reports (SF–269) are due 90 days after each budget period and the final SF–269 must be verified from the grantee records on how the value was derived.

F. Federal Subaward Reporting System (FSRS)

This award may be subject to the Transparency Act subaward and executive compensation reporting requirements of 2 CFR Part 170. The FFATA "Transparency Act", requires the OMB to establish a single searchable database, accessible to the public, with information on financial assistance awards made by Federal agencies. The Transparency Act also includes a requirement for recipients of Federal grants to report information about first-tier subawards and executive compensation under Federal assistance awards.

Effective as of October 1, 2010, IHS implemented a Term of Award into all Notice of Awards issued on/after the date of this announcement by incorporating it on all IHS Standard Terms and Conditions. For the full IHS award term implementing this requirement and additional award applicability information see the Grants Policy Web site at: *http://www.ihs.gov/NonMedicalPrograms/gogp/index.cfm?module=gogp_policy_topics*

Although referenced on all Notices of Award, the following IHS Term of Award is applicable to all New (Type 1) IHS grant and cooperative agreement awards issued on or after October 1, 2010. Additionally, all IHS Renewal (Type 2) grant and cooperative agreement awards and Competing Revision awards (Competing T–3s) issued on or after October 1, 2010 may also be subject to the following award term. Further guidance on Renewal and Competing Revision awards is expected to be provided as it becomes available. Telecommunication for the hearing impaired is available at: TTY (301) 443–6394.

G. Unmet Needs Report

An unmet needs report is required quarterly. These reports will include information gathered to: (1) Identify gaps between unmet health needs of urban Indians and the resources available to meet such needs; and (2) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians.

VII. Agency Contacts

For program-related information:

Phyllis S. Wolfe, Director, Office of Urban Indian Health Programs, 801 Thompson Avenue, Suite 200, Rockville, Maryland 20852. (301) 443–4680 or *phyllis.wolfe@ihs.gov.*

For general information regarding this announcement:

Danielle Steward, Health Systems Specialist, Office of Urban Indian Health Programs, 801 Thompson Avenue, Room 200, Rockville, MD 20852. (301) 443–4680 or *danielle.steward@ihs.gov.*

For specific grant-related and business management information:

Pallop Chareonvootitam, Grants Management Specialist, 801 Thompson Avenue, TMP 360, Rockville, MD 20852. (301) 443–5204 or *pallop.chareonvootitam@ihs.gov.*

Dated: February 7, 2011.

Yvette Roubideaux,

Director, Indian Health Service.

Appendix—Title V Urban Indian Health 4-in-1 Grants

1. Indian Health Service Area HP/DP Coordinators
2. Indian Health Service Behavioral Health Area Consultants
3. Indian Health Service Area GPRA Coordinators
4. Indian Health Service/Veterans Health Administration Area Points of Contact

Indian Health Service Area HP/DP Coordinators

Aberdeen Area IHS Office

Janelle Trottier, MSW, LCSW, Aberdeen Area Health Systems Specialist, 115 Fourth Avenue, SE, Rm 309, Aberdeen, SD 57401, Phone: (605) 226–7474, Fax: (605) 226–7670, Email: *janelle.trottier@ihs.gov.*.

Albuquerque Area IHS Office

Alaska Area IHS Office

Margaret David, BS, Alaska Native Tribal Health Consortium, Community Health Services, Office of Alaska Native Health Research, 4000 Ambassador Drive—Floor 4, Anchorage, AK 99508, Phone: (907) 729–3634, Fax: (907) 729–3652, Email: *mohdavid@anthc.org.*

Bemidji Area IHS Office

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Billings Area IHS Office

VACANT, 2900 4th Ave. N., P.O. Box 36600, Billings, MT 59107, Phone: (406) 247–7118, Fax: (406) 247–7231, Email:.

Nashville Area IHS Office

VACANT, 711 Stewarts Ferry Pike, Nashville, TN 37214–2634, Phone: (615) 467–1628, Fax: (615) 467–1665, Email:.

Oklahoma Area IHS Office

Freda Carpitcher, MPH, Five Corporate Plaza, 3625 NW 56th Street, Oklahoma City, OK 73112, Phone: (405) 951–3717, Fax: (405) 951–3916 , Email: *freda.carpitcher@ihs.gov*..

Portland Area IHS Office

Joe W. Law, BS, 1414 NW Northrup St., Ste. 800, Portland, OR 97209, Phone: (503) 414–5597, Fax: (503) 414–7795, Email: *joe.law@ihs.gov*.

IHS National Programs Albuquerque

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Michelle Archuleta, MS, 522 Minnesota Ave., NW, Bemidji, MN 56601, Phone: (218) 444–0492, Fax: (218) 444–0513, Email: *michelle.archuleta@ihs.gov*.

California Area IHS Office

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Navajo Area IHS Office

Marie Nelson, BS, Navajo Area Indian Health Service, P.O. Box 9020 (NAIHS Complex), Window Rock, AZ 86515–9020, Phone: (928) 871–1338, Fax: (928) 871–5872, Email: *marie.nelson@na.ihs.gov*.

Phoenix Area IHS Office

Shannon Beyale, MPH, Phoenix Area Indian Health Service, Two Renaissance Square, 40 North Central Ave., Phoenix AZ 85004, Phone: (602) 364–5155, Fax: (602) 364–5025, Email: *Shannon.beyale@ihs.gov*.

Tucson Area IHS Office

Shawnell Damon, MPH, 7900 South "J" Stock Road, Tucson, AZ 85746–7012, Phone: (520) 295–2492, Fax: (520) 295–2602, Email: *shawnell.damon@ihs.gov.*

DIVISION OF BEHAVIORAL HEALTH

Behavioral Health Area Consultants Point of Contacts

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Vicki Claymore-Lahammer, PhD, (605) 226–7341, *vicki.claymore-lahammer@ihs.gov*.	Federal Building, 115 Fourth Avenue, SE., Aberdeen, SD 57401.
ALBUQUERQUE:	
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ALASKA:	
Kathleen Graves, PhD, (907) 729–4594, *kgraves@anmc.org*	4000 Ambassador Drive, Room 443, Anchorage, AK 99508.
BEMIDJI:	
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Dawn M. Phillips, R.N., M.P.A., (916) 930–3981, Ext. 331, *dawn.phillips@ihs.gov*.	Do.
NASHVILLE:	
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NAVAJO:	
Jayne Talk-Sanchez, (505) 368–7420, *jayne.talk-sanchez@ihs.gov*	N. HWY 666, P.O. Box 160, Shiprock, NM 87420.
OKLAHOMA:	
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PHOENIX:	
David Atkins, LISW, ACSW, (602) 364–5159, *david.atkins@ihs.gov*	40 North Central Avenue, Suite 606, Phoenix, AZ 85004.
David McIntyre, (602) 364–5183, *david.mcintyre@ihs.gov*, Mental Health Consultant.	Do.
Linda Westover, LCSW, (602) 364–5157, *linda.westover@ihs.gov*, Social Work Consultant.	Do.
PORTLAND:	
Ann Arnett, (503) 326–2005, *Ann.arnett@ihs.gov*	1220 SW. Third Avenue, Room 476, Portland, OR 97204.
TUCSON:	
Patricia Nye, MD, LISAC, (520) 295–2469, *patricia.nye@ihs.gov* ...	7900 South J Stock Road, Tucson, AZ 85746.
HQ STAFF:	
Shelly Carter, (301) 443–0226, *shelly.carter@ihs.gov*	801 Thompson Ave., Suite 300, Rockville, MD 20852.
Michele Muir, (301) 443–2040, *michele.muir@ihs.gov*	Do.
Rose Weahkee, PhD, (301) 443–1539, *rose.weahkee@ihs.gov*	Do.
Amina Bashir, (301) 443–6581, *amina.bashir@ihs.gov*	Do.
Debbie Black, (301) 443–8028, *debbie.black@ihs.gov*	Do.
Jon Perez, PhD, (301) 281–1777, *jon.perez@ihs.gov*	Phoenix, AZ.

AREA GPRA COORDINATORS AS OF AUGUST 2009

Area	GPRA coordinator(s)	Contact information
Aberdeen	Janelle Trottier	*janelle.trottier@ihs.gov*, (605) 226–7474
Alaska	Bonnie Boedeker	*Bonnie.Boedeker@ihs.gov*, (907) 729–3665.
Albuquerque	Steve Petrakis	*steve.petrakis@ihs.gov*, (505) 248–1361.
Bemidji	Jason Douglas	*Jason.Douglas@ihs.gov*, (218) 444–0550.
Billings	Carol Strashiem	*carol.strasheim@ihs.gov*, (406) 247–7111.
California	Elaine Brinn	*Elaine.Brinn@ihs.gov*, (916) 930–3927 ext. 320.
Nashville	Kristina Rogers	*Kristina.Rogers@ihs.gov*, (615) 467–2926.
Navajo	Jenny Notah	*Genevieve.Notah@ihs.gov*, (928) 871–5836.
Oklahoma	Marjorie Rogers	*Marjorie.Rogers@mail.ihs.gov*, (405) 951–6020.
Phoenix	Jody Sekerak	*Jody.Sekerak@ihs.gov*, (602) 364–5274.
Portland	Mary Brickell	*Mary.Brickell@ihs.gov*, (503) 326–5592.
Tucson	Scott Hamstra, M.D	*Scott.hamstra@ihs.gov*, (520) 295–2406.

IHS/VA AREA POINTS OF CONTACT

IHS			VA		
Aberdeen Area—North Dakota, South Dakota, Iowa, Nebraska.	Dr. George Ceremuga (Acting).	*george.ceremuga@ihs.gov,* (605)-964–7724.	VISN 23—South Dakota, North Dakota, Nebraska, Iowa, Minnesota.	Ms. Carla Belle Alexander.	*carlabelle.alexander@va.gov,* (605) 720–7337.
Alaska Area—Alaska	Dr. Kenneth Glifort	*Kenneth.Glifort@ihs.gov,* (907) 729–3686.	VISN 20—Alaska, Idaho, Oregon, Washington.	Mr. Alexander Spector.	*alexander.spector@va.gov,* (907) 257–5460.
Albuquerque Area—Colorado, New Mexico, Texas.	Dr. Leonard Thomas	*Lenonard.Thomas@ihs.gov, (505) 248–4115.*	VISN 18—New Mexico, Texas, Arizona.	VISN 18—Ms. Deborah Thompson.	*deborah.thompson7ec@va.gov,* (928) 776–6001.
			VISN 19—Colorado, Utah, Montana.	VISN 19—Mr. James Floyd.	*james.floyd@va.gov,* (801) 582–1565 x1500.
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			VISN 12—Illinois, Wisconsin, Michigan.	VISN 12—Dr. Ed Zarling.	*edwin.zarling@va.gov,* (708) 202–8413.
			VISN 23—Minnesota, SD, ND, IA, NE.	VISN 23—Ms. Carla Belle Alexander.	*carlabelle.alexander@va.gov,* (605) 720–7337.
Billings—Montana, Wyoming.	Dr. Doug Moore	*doug.moore@ihs.gov,* (406) 247–7129.	VISN 19—Wyoming, Colorado, Montana, Utah.	Mr. James Floyd	*james.floyd@va.gov,* (801) 582–1565 x1500.
California—California, Hawaii.	Dr. David Sprenger	*david.sprenger@ihs.gov,* (916) 930–3981.	VISN 21—Northern California, Hawaii, Nevada.	VISN 21—Ms. Martha Akrop.	*martha.akrop@va.gov,* (775) 328–1428.
			VISN 22—So. California, Nevada.	VISN 22—Ms. Barbara Fallen.	*barbara.fallen@va.gov,* (562) 826–5963.
Headquarters—Washington D.C./Rockville MD.	Dr. Susan Karol Mr. Leo Nolan	*susan.karol@ihs.gov,* (301) 443–1083. *leo.nolan@ihs.gov,* (301)-443–7261.	VA Central Office	Ms. Louise Van Diepen.	*Louise.VanDiepen@va.gov,* (202) 273–5878.
Nashville—TX, LA, AR, MS, AL, MO, IL, IN, TN, KY, OH, GA, FL, SC, NC, VA, WV, PA, MD, DC, DE, NY, CT, MA, VT, NH, RI, ME, NJ.	Ms. Elizabeth Neptune.	*Elizabeth.Neptune@ihs.gov,* (207) 214–6524..	VISN 1—MA, NH, CT, RI, ME, VT.	VISN 1—Dr. Gail Goza-MacMullan.	*gail.goza-macmullan@med.va.gov,* (781) 687–3412.
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			VISN 8—FL, PR	VISN 8—TBD	TBD.
			VISN 12—IL, MI, WI	VISN 12—Dr. Ed Zarling.	*edwin.zarling@va.gov,* (708) 202–8413
				VISN 15—Dr. James Sanders.	*james.sanders@med.va.gov,* (816) 701–3000.
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			VISN 17—TX	VISN 17—Mr. Jack Dufon.	*jack.dufon2@med.va.gov,* (817) 385–3786.
			VISN 18—NM, TX, AZ.	VISN 18—Ms. Deborah Thompson.	*deborah.thompson7ec@va.gov,* (928) 776–6001.
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			VISN 19—Wyoming, Colorado, Montana, Utah.	VISN 19—Mr. James Floyd.	*james.floyd@va.gov,* (801) 582–1565 x1500.
Oklahoma—Oklahoma, Kansas, Texas.	Dr. John Farris	*John.Farris@ihs.gov,* (405) 951–3776.	VISN 15—Kansas, Missouri.	VISN 15—Dr. James Sanders.	*james.sanders@med.va.gov,* (816) 701–3000.
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IHS/VA AREA POINTS OF CONTACT—Continued

IHS			VA		
Phoenix—Nevada, Utah, Arizona.	Dr. Charles (Ty) Reidhead. Dr. Augusta Hays (alt.).	*charles.reidhead@ihs.gov,* (602) 364–5039. *Augusta.Hays@ihs.gov,* (602) 364–5039.	VISN 18—New Mexico, Texas, Arizona. VISN 18—New Mexico, Texas, Arizona. VISN 19—Wyoming, Colorado, Montana, Utah. VISN 21—Northern California, Hawaii, Nevada. VISN 22—So. California, Nevada.	VISN 18—Ms. Deborah Thompson. VISN 18—Ms. Deborah Thompson. VISN 19—Mr. James Floyd. VISN 21—Ms. Martha Akrop. VISN 22—Ms. Barbara Fallen.	*deborah.thompson7ec@va.gov,* (928) 776–6001. *deborah.thompson7ec@va.gov,* (928) 776–6001. *james.floyd@va.gov,* (801) 582–1565 x1500. *Martha.Akrop@va.gov,* (775) 328–1428. *barbara.fallen@va.gov,* (562) 826–5963.
Portland—Washington, Oregon, Idaho.	Mr. Terry Dean	*Terry.Dean@ihs.gov,* (503) 326–7270.	VISN 20—Alaska, Idaho, Oregon, Washington.	Mr. Alexander Spector.	*alexander.spector@va.gov,* (907) 257–5460.
Tucson—Arizona	Dr. John R. Kittredge	*John.Kittredge@ihs.gov,* (520) 295–2406.	VISN 18—New Mexico, Texas, Arizona.	Ms. Deborah Thompson.	*deborah.thompson7ec@va.gov,* (928) 776–6001.

[FR Doc. 2011–3856 Filed 2–18–11; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form G–845 and Supplement; Revision of a Currently Approved Information Collection; Comment Request

ACTION: *60-Day Notice of Information Collection Under Review:* Form G–845 and Supplement; Document Verification Request, and Document Verification Request Supplement; OMB Control No. 1615–0101.

The Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) will be submitting the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for sixty days until April 25, 2011.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), USCIS, Chief, Regulatory Products Division, Office of the Executive Secretariat, 20 Massachusetts Avenue, NW., Washington, DC 20529–2020. Comments may also be submitted to DHS via facsimile to 202–272–0997 or via e-mail at *rfs.regs@dhs.gov.* When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0101 in the subject box.

Note: The address listed in this notice should only be used to submit comments concerning the revision of this information collection. Please do not submit requests for individual case status inquiries to this address. If you are seeking information about the status of your individual case, please check "My Case Status" online at: *https://egov.uscis.gov/cris/Dashboard.do,* or call the USCIS National Customer Service Center at 1–800–375–5283 (TTY 1–800–767–1833).

Written comments and suggestions from the public and affected agencies concerning the collection of information should address one or more of the following four points:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of this information collection:

(1) *Type of Information Collection:* Revision of a currently approved information collection.

(2) *Title of the Form/Collection:* Document Verification Request and Document Verification Request Supplement.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form G–845 and Supplement. U.S. Citizenship and Immigration Services.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract:* Primary: Individuals and households. The information collections allow for the verification of immigration status of certain persons applying for benefits under certain entitlement programs.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* Form G–845—248,206 responses at 5 minutes (.083) per response; Supplement—11,247 responses at 5 minutes (.083) per response; Automated Queries 11,839,892 responses at 5 minutes (.083) per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 1,004,246 annual burden hours.

If you need a copy of this information collection instrument, please visit the Web site at: *http://www.regulations.gov/.*

We may also be contacted at: USCIS, Regulatory Products Division, Office of the Executive Secretariat, 20 Massachusetts Avenue, NW., Washington, DC 20529–2020, Telephone number 202–272–8377.

Dated: February 15, 2011.

Sunday Aigbe,

Chief, Regulatory Products Division, Office of the Executive Secretariat, U.S. Citizenship and Immigration Services, Department of Homeland Security.

[FR Doc. 2011–3786 Filed 2–18–11; 8:45 am]

BILLING CODE 9111–97–P