affect financial markets, borrowers, and consumers. FHFA intends that the availability of this information, as well as the research and analyses derived from it, will provide sufficient warning to allow it and other regulators to take steps to avoid, or at least to mitigate, major mortgage market crises in the future.

B. Burden Estimate

FHFA estimates the total annual average number of survey recipients at 28,000 (7,000 × 4 calendar quarters), with one response per recipient. The estimate for the average amount of time to complete each survey is 30 minutes. The estimate for the total annual hour burden for respondents is 14,000 hours (28,000 respondents × 0.5 hours).

C. Comment Request

FHFA requests written comments on the following: (1) Whether the collection of information is necessary for the proper performance of FHFA functions, including whether the information has practical utility; (2) The accuracy of FHFA's estimates of the burdens of the collection of information; (3) Ways to enhance the quality, utility, and clarity of the information collected; and (4) Ways to minimize the burden of the collection of information on survey respondents, including through the use of automated collection techniques or other forms of information technology.

Dated: April 19, 2013.

Kevin Winkler,

Chief Information Officer, Federal Housing Finance Agency.

[FR Doc. 2013–09702 Filed 4–24–13; 8:45 am]

BILLING CODE 8070–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the President's Council on Fitness, Sports, and Nutrition; Correction

AGENCY: Office of the President's Council on Fitness, Sports, and Nutrition, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice; correction.

SUMMARY: The Department of Health and Human Services published a notice in the **Federal Register** of April 11, 2013 to announce a meeting of the President's Council on Fitness, Sports, and Nutrition that will be held on May 7, 2013, from 10:00 a.m. to 4:30 p.m., at the Department of Health and Human Services, 200 Independence Ave. SW., Room 800; Washington, DC 20201. The meeting location has changed.

FOR FURTHER INFORMATION CONTACT: Ms. Shellie Pfohl, Executive Director, President's Council on Fitness, Sports, and Nutrition. Phone: (240) 276–9866 or (240) 276–9567.

Correction

In the **Federal Register** of April 11, 2013, FR Doc. 2013–08494 on page 21606, in the second column, correct the **ADDRESSES** caption to read:

ADDRESSES: Department of Health and Human Services, 200 Independence Ave. SW., Great Hall, Washington, DC 20201.

Dated: April 18, 2013.

Shellie Y. Pfohl,

Executive Director, President's Council on Fitness, Sports, and Nutrition.

[FR Doc. 2013–09815 Filed 4–24–13; 8:45 am]

BILLING CODE 4150–35–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–13–0853]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov*. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Asthma Information Reporting System (AIRS) (0920–0853, Expiration 06/30/2013)—Extension—Air Pollution and Respiratory Health Branch (APRHB), National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Under the authority of the Public Health Service Act, CDC is seeking a three-year extension of OMB approval for the Asthma Information Reporting System (AIRS) information collection. In 1999, the CDC initiated its National Asthma Control Program, a population-based public health approach to address the burden of asthma. The program supports the goals and objectives of ''Healthy People 2020'' for asthma and is based on the public health principles of surveillance, partnerships, and interventions. Through AIRS, the information collection request has and will continue to provide NCEH with routine information about the activities and performance of the state and territorial grantees funded under the National Asthma Control Program *http://www.cdc.gov/asthma/nacp.htm.*

The primary purpose of the National Asthma Control Program is to develop program capacity to address asthma from a public health perspective to bring about: (1) A focus on asthma-related activity within states; (2) an increased understanding of asthma-related data and its application to program planning and evaluation through the development and maintenance of an ongoing asthma surveillance system; (3) an increased recognition, within the public health structure of states, of the potential to use a public health approach to reduce the burden of asthma; (4) linkages of state health agencies to other agencies and organizations addressing asthma in the population; and (5) implementation of interventions to achieve positive health impacts, such as reducing the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma.

Prior to the implementation of AIRS, data were collected on a semi-annual basis from state asthma control programs as part of regular reporting of cooperative agreement activities. States reported information such as progress-to-date on accomplishing intended objectives, programmatic changes, changes to staffing or management, and budgetary information.

As implemented since 2010, the AIRS management information system is comprised of multiple components that enable the electronic reporting of three types of data/information from state asthma control programs: (1) Information that is currently collected as part of regular programmatic reporting, (2) Aggregate level reports of surveillance data on long-term program outcomes, and (3) Specific data indicative of progress made on partnerships, surveillance, interventions, and evaluation.

Regular reporting of this information remains a requirement of the current cooperative agreement mechanism utilized to fund state asthma control programs. States are asked to submit interim and year-end progress report information into AIRS, thus this type of

programmatic information on activities and objectives will continue to be collected twice per year.

The National Asthma Control Program at CDC has access to and analyzes national-level asthma surveillance data (*http://www.cdc.gov/asthma/asthmadata.htm*). With the exception of data from the Behavioral Risk Factor Surveillance System (BRFSS), state level analyses cannot be performed. Therefore, as part of AIRS, state asthma control programs submit aggregate surveillance data to allow calculation of asthma surveillance indicators across all funded states (where data are available) in a standardized manner. Data requests through this system regularly include: Hospital discharges (with asthma as first listed diagnosis), and emergency department visits (with asthma as first listed diagnosis). Under AIRS, participating states annually submit this information to the AIRS system in conjunction with an end-of-year report describing state activities that meet project objectives described above.

National and state asthma surveillance data provide information useful to examine progress on long-term outcomes of state asthma programs. To identify appropriate indicators of program implementation and short-term outcomes for AIRS, CDC previously convened and facilitated workgroups comprised of state asthma control program representatives to generated specific questions to collect data on key features of state asthma control programs: Partnerships, surveillance, interventions, and evaluation.

With technical assistance provided by NCEH staff, AIRS has provided states with uniform data reporting methods and linkages to other states' asthma programs and data. Thus, AIRS has saved state resources and staff time when they embark on asthma activities similar to those being done elsewhere. Also, the AIRS system has been similarly helpful in linking states together on occasions when a given state seeks to report their results at national meetings or publish their findings and program results in scholarly journals. For example, with CDC staff, three state programs co-presented on a panel regarding evaluations of their asthma partnerships at the November, 2012 American Evaluation Association's *Evaluation 2012* conference.

In addition, CDC staff have regularly made requests from AIRS to obtain standardized summaries of state programs regarding such activities as the number of states meeting staffing requirements, number and timeliness of state strategic evaluation plans, topics for individual evaluation selected by states, types and targets of interventions, and use of asthma surveillance data in state programs.

Furthermore, access to standardized AIRS surveillance and programmatic data allows CDC to provide timely and accurate responses to the public and Congress regarding the NCEH asthma program (e.g., how many states have asthma interventions targeting schools, how many children are treated in emergency departments, etc.).

There will be no cost for respondents, other than their time, to participate in AIRS. Based on the program's evaluation of past performance, it was noted that the hours for the interim report should be increased from 2 to 4 hours and those of the end of year be decreased from 6 to 4 hours; however, total burden hours remain at 8 hours per year per respondent. The total estimated annual burden hours are 288.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
State Health Departments	Interim report on activities and objectives	36	1	4
State Health Departments	End of year report on activities, objectives and aggregate surveillance.	36	1	4

Ron A. Otten,

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

[FR Doc. 2013–09756 Filed 4–24–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Child Support Noncustodial Parent Employment Demonstration (CSPED).

OMB No.: 0970—NEW.

Description: The Office of Child Support Enforcement (OCSE) within the Administration for Children and Families (ACF) is proposing data collection activity as part of the Child Support Noncustodial Parent Employment Demonstration (CSPED). In October 2012, OCSE issued grants to eight state child support agencies to provide employment, parenting, and child support services to noncustodial parents who are having difficulty meeting their child support obligation. The overall objective of the CSPED evaluation is to document and evaluate the effectiveness of the approaches taken by these eight CSPED grantees. This evaluation will yield information about effective strategies for improving child support payments by providing noncustodial parents employment and other services through child support programs. It will generate extensive information on how these programs operated, what they cost, the effects the programs had, and whether the benefits of the programs exceed their costs. The information gathered will be critical to informing decisions related to future investments in child support-led employment-focused programs for noncustodial parents who have difficulty meeting their child support obligations.

The CSPED evaluation will include the following two interconnected components or ''studies'':

1. Implementation and Cost Study. The goal of the implementation and cost study is to provide a detailed description of the programs—how they are implemented, their participants, the contexts in which they are operated, their promising practices, and their costs. The detailed descriptions will assist in interpreting program impacts, identifying program features and conditions necessary for effective program replication or improvement, and carefully documenting the costs of delivering these services. Key activities of the implementation and cost study will include: (1) Conducting semi-structured interviews with program staff