[52] The Maine Indian Claims Settlement Act of 1980 (Pub. L. 96–420; H. Rept. 96–1353) includes the intent of Congress to fund and provide contract health services to the Passamaquoddy Tribe and the Penobscot Nation.

[53] The Passamaquoddy Tribe has two reservations: Indian Township and Pleasant Point. The PRCDA for the Passamaquoddy Tribe at Indian Township, ME, is Aroostook County, ME, Washington County, ME, and Hancock County, ME. The PRCDA for the Passamaquoddy Tribe at Pleasant Point, ME, is Washington County, ME, south of State Route 9, and Aroostook County, ME.

[54] The Passamaquoddy Tribe's counties listed are designated administratively as the SDA, to function as a PRCDA, for the purposes of operating a PRC program pursuant to the ISDEAA, Public Law 93–638.

[55] The Maine Indian Claims Settlement Act of 1980 (Pub. L. 96–420; H. Rept. 96–1353) includes the intent of Congress to fund and provide PRC to the Passamaquoddy Tribe and the Penobscot Nation.

[56] Counties in the Service Unit designated by Congress for the Poarch Band of Creek Indians (see H. Rept. 98–886, June 29, 1984; Cong. Record, October 10, 1984, Pg. H11929).

[57] Public Law 103–323 restored Federal recognition to the Pokagon Band of Potawatomi Indians, Michigan and Indiana, in 1994 and identified counties to serve as the SDA.

[58] The Ponca Restoration Act, Public Law 101–484, recognized members of the Ponca Tribe of Nebraska in Boyd, Douglas, Knox, Madison or Lancaster counties of Nebraska or Charles Mix county of South Dakota as residing on or near a reservation. Public Law 104–109 made technical corrections to laws relating to Native Americans and added Burt, Hall, Holt, Platte, Sarpy, Stanton, and Wayne counties of Nebraska and Pottawatomie and Woodbury counties of Iowa to the Ponca Tribe of Nebraska SDA.

[59] Special programs have been established by Congress irrespective of the eligibility regulations. Eligibility for services at these facilities is based on the legislative history of the appropriation of funds for the particular facility, rather than the eligibility regulations. Historically services have been provided at Rapid City (S. Rept. No. 1154, FY 1967 Interior Approp. 89th Cong. 2d Sess.).

[60] The Thomasina E. Jordan Indian Tribes of Virginia Federal Recognition Act of 2017, Public Law 115–121, officially recognized the Rappahannock Tribe, Inc. as an Indian Tribe within the meaning of Federal law, and specified an area for the delivery of Federal services. The IHS administratively designated the Tribe's PRCDA, for the purposes of operating a PRC program, consistent with the Congressional intent expressed in the Recognition Act.

[61] Historically part of Isabella Reservation Area for the Saginaw Chippewa Indian Tribe of Michigan and the Eastern Michigan Service Unit population since 1979.

[62] The Samish Indian Tribe Nation was Federally acknowledged in April 1996 as documented at 61 FR 15825, April 9, 1996. The counties listed were designated administratively as the SDA, to function as a CHSDA, for the purposes of operating a CHS program pursuant to the ISDEAA, Public Law 93–638.

[63] CHSDA counties for the Sault Ste. Marie Tribe of Chippewa Indians, Michigan, were designated by regulation (42 CFR 136.22(a)(4)).

[64] The Shinnecock Indian Nation was Federally acknowledged in June 2010 as documented at 75 FR 34760, June 18, 2010. The counties listed were designated administratively as the SDA, to function as a CHSDA, for the purposes of operating a CHS program pursuant to the ISDEAA, Public Law 93–638.

[65] Lemhi County, ID, has historically been a part of the Fort Hall Service Unit population since 1979.

[66] The Snoqualmie Indian Tribe was Federally acknowledged in August 1997 as documented at 62 FR 45864, August 29, 1997. The counties listed were designated administratively as the SDA, to function as a CHSDA, for the purposes of operating a CHS program pursuant to the ISDEAA, Public Law 93–638.

[67] On December 30, 2011 the Office of Assistant Secretary-Indian Affairs reaffirmed the Federal recognition of the Tejon Indian Tribe. Kern County, CA, was designated administratively as part of the Tribe's CHSDA in addition to the CHSDA established by Congress for the State of California. Kern County was not covered when Congress originally established the State of California as a CHSDA excluding certain counties including Sacramento County (25 U.S.C. 1680).

[68] The counties listed are designated administratively as the SDA, to function as a PRC SDA, for the purposes of operating a PRC program pursuant to the ISDEAA, Public Law 93–638.

[69] The Secretary acting through the Service is directed to provide contract health services to Turtle Mountain Band of Chippewa Indians that reside in Trenton Service Unit, North Dakota and Montana, in Divide, Mackenzie, and Williams counties in the state of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the state of Montana (Sec. 815, Pub. L. 94–437).

[70] Rapides County, LA, has historically been a part of the Tunica Biloxi Service Unit population since 1982.

[71] The Thomasina E. Jordan Indian Tribes of Virginia Federal Recognition Act of 2017, Public Law 115–121, officially recognized the Upper Mattaponi Tribe as an Indian Tribe within the meaning of Federal law, and specified an area for the delivery of Federal services. The IHS administratively designated the Tribe's PRCDA, for the purposes of operating a PRC program, consistent with the Congressional intent expressed in the Recognition Act.

[72] according to Public Law 100–95, Sec. 12, members of the Wampanoag Tribe of Gay Head (Aquinnah) residing on Martha's Vineyard are deemed to be living on or near an Indian reservation for the purposes of eligibility for Federal services.

[73] The counties listed are designated administratively as the SDA, to function as a PRCDA, for the purposes of operating a PRC program pursuant to the ISDEAA, Public Law 93–638.

[74] The Wilton Rancheria, California had Federal recognition restored in July 2009 as documented at 74 FR 33468, July 13, 2009. Sacramento County, CA, was designated administratively as part of the Rancheria's CHSDA in addition to the CHSDA established by Congress for the State of California. Sacramento County was not covered when Congress originally established the State of California as a CHSDA excluding certain counties including Sacramento County (25 U.S.C. 1680).

[75] Public Law 100–89, Restoration Act for Ysleta Del Sur and Alabama and Coushatta Tribes of Texas establishes service areas for "members of the Tribe" by sections 101(3) and 105(a) for the Pueblo and sections 201(3) and 206(a) respectively.

Elizabeth A. Fowler,

Acting Director, Indian Health Service.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Addressing Dementia in Indian Country: Models of Care

Announcement Type: New.

Funding Announcement Number: HHS–2022–IHS–ALZ–0001.

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.933.

Key Dates

Application Deadline Date: July 18, 2022.

Earliest Anticipated Start Date: August 31, 2022.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for cooperative agreements for Addressing Dementia in Indian Country. This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the Indian Health Care Improvement Act, 25 U.S.C. 1665a(c)(5)(F) and 1660e. This program is described in the Assistance Listings located at *https://sam.gov/content/home* (formerly known as the CFDA) under 93.933.

Background

Alzheimer's disease and Alzheimer's disease-related dementias affect lives in every Tribal and Urban Indian community. Alzheimer's disease is the most common cause of dementia—a progressive cognitive impairment that adversely affects function. Other forms

of dementia include vascular dementia, Lewy-Body Disease, Fronto-Temporal Dementia, alcohol-related dementia, dementia related to traumatic brain injury, and mixed dementia (attributable to more than one cause of cognitive impairment). Age is the most significant risk factor for Alzheimer's disease. Although the average age of American Indians and Alaska Natives (AI/AN) is younger than the population as a whole, the group age 65 and older is growing more rapidly than the United States (U.S.) population. The Centers for Disease Control and Prevention (CDC) notes that the number of AI/AN age 65 and older is expected to triple in the next 30 years, with the oldest—those 85 years and older—increasing even more rapidly. While age is the most substantial risk factor for Alzheimer's disease, early-onset occurs in younger populations and in persons with Down Syndrome or Trisomy 21, who are at markedly increased risk for Alzheimer's Disease. Conditions such as diabetes, cardiovascular disease, chronic kidney disease, chronic liver disease, and traumatic brain injury increase the risk of dementia and can lead to a more rapid worsening.

Dementia of all types is under-recognized, underdiagnosed, and undertreated in all populations in the U.S., and anecdotal evidence suggests that this is very much true for the AI/AN population. Many individuals go unrecognized in the community, never seeking care and living with impaired cognition that puts them at risk for financial exploitation, poor health outcomes, and accidental injury. Individuals and their families may not recognize the cognitive changes that dementia brings. They may think the changes are due to normal aging or may accept the changes and not seek care out of concern for the elder's dignity. Failure to recognize dementia may also stem from the stigma associated with dementia and from lack of awareness of resources available. Often it takes a crisis or illness to bring attention to the condition. Diagnosis of dementia is most often made in the primary care office or clinic, with specialty referral needed when the presentation is not typical or apparent. But primary care providers may lack the confidence to make the diagnosis or plan effective care and may not have access to an interdisciplinary team to support care or specialists through consultation or referral to support diagnosis and management decisions. Effective management of dementia crosses many boundaries, involving medical care, personal care, social services, legal and financial services, and housing. Management of dementia requires coordination between clinical services and community-based services. Those living with dementia and their caregivers are too often left to coordinate this complex care themselves. Most persons living with dementia receive some care and assistance from caregivers, and sometimes from family members. Care for the person living with dementia should include consideration for their caregivers but, unfortunately, this is not common.

Effective models for addressing dementia in Tribal and Urban Indian communities will be supported by evidence and will emerge through development or adaptation and evaluation from those communities. A recent report by the Agency for Healthcare Research and Quality and the National Academies of Science, Engineering, and Medicine point to the Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) caregiver support intervention and models of coordinated care as interventions that have evidence for benefit and are ready for implementation and further evaluation.[1] The REACH into Indian Country initiative successfully trained public and community health nurses to provide the REACH intervention in Tribal communities. Communities across the country, including some Tribal communities, use the Dementia-Friendly Communities approach to building community-based efforts to improve care for persons living with dementia and their families.[2] The Healthy Brain Initiative Roadmap for Indian Country, developed by the CDC and the Alzheimer's Association, is designed to support discussion about dementia and caregiving with Tribal communities and encourage a public health approach as part of a larger holistic response.[3] These models can help inform the design of Tribal and Urban Indian health models.

Purpose

The purpose of this program is to support the development of models of comprehensive and sustainable dementia care and services in Tribal and Urban Indian communities that are responsive to the needs of persons living with dementia and their caregivers. Awardees will:

1. Plan and implement a comprehensive approach to care and services for persons living with dementia and their caregivers that addresses:

- Awareness and Recognition. Enhance awareness and early recognition of dementia in the community and increase referral to clinical care for evaluation leading to diagnosis. The United States Preventive Services Task Force has concluded that ''current evidence is insufficient to assess the benefits and harms of screening for cognitive impairment in older adults.'' Still, there is broad consensus supporting case findings to promote early recognition and diagnosis of dementia.
- Accurate and Timely Diagnosis. Individuals and their families should have confidence that concerns about potential cognitive impairment will be evaluated thoroughly and lead to an accurate and timely diagnosis. Most diagnoses of dementia can be made in primary care, but clinical programs should have referral and consultation mechanisms in place (either in person or via telehealth) to support diagnosis when needed.
- Interdisciplinary Assessment. Persons living with dementia will have complex and evolving care needs. An interdisciplinary assessment helps identify goals of care and gaps in services and sets the stage for appropriate care and services. In best practice, this assessment includes an attempt to understand the cultural, religious, and personal values that will guide goals and preferences for care. It assesses family and other caregiving resources and the needs and capabilities of those partners in care, as well as housing security and safety risks.
- Management and Referral. Care for the person living with dementia is guided by the assessment and most often requires coordination of health care and social services to meet their needs and support caregivers. Those living with dementia and their caregivers often need support and assistance in navigating through the various systems providing this care.
- Support for Caregivers. Care for persons living with dementia includes care for their caregivers. Families and other caregivers need help in navigating services and mobilizing respite care, help in understanding what to expect and how to respond to the challenges of living with dementia, and support for

[1] National Academies of Sciences, Engineering, and Medicine. 2021. Meeting the challenge of caring for persons living with dementia and their care partners and caregivers: A way forward. Washington, DC: The National Academies Press. *https://doi.org/10.17226/26026.*

[2] Dementia Friendly America *https://www.dfamerica.org https://iasquared.org/news-release-ia2-is-now-a-national-dementia-friends-sub-licensee-for-american-indian-and-alaska-native-tribal-communities/.*

[3] *https://www.cdc.gov/aging/healthybrain/indian-country-roadmap.html.*

self-care. Interventions that provide that care and support (*e.g.,* REACH) and provide education and training (*e.g.,* Savvy Caregiver) have been adapted for use in Tribal communities.

2. Develop, in collaboration with the IHS, best and promising practices to include tools, resources, reports, and presentations accessible to Federal, Tribal, and urban health programs as they plan and implement their own programs.

3. Identify and implement reimbursement and funding streams that will support service delivery and facilitate sustainability. Opportunities for reimbursement and funding streams dependent on the specific interventions planned, but potential sources might include:

- Medicare reimbursement through the Physician Fee Schedule, including Cognitive Assessment and Planning codes and Chronic and Complex Care Management codes.
- Medicaid and other state programs.
- Purchased and Referred Care resources.
- IHS and Third Party Revenue.

The IHS Alzheimer's Grant Program will provide technical assistance to grantees in development of a plan for sustainability.

II. Award Information

Funding Instrument—Cooperative Agreement

Estimated Funds Available

The total funding identified for fiscal year (FY) 2022 is approximately $1,000,000. Individual award amounts for the first budget year are anticipated to be between $100,000 and $200,000. The funding available for competing and subsequent continuation awards issued under this announcement is subject to the availability of appropriations and budgetary priorities of the Agency. The IHS is under no obligation to make awards that are selected for funding under this announcement.

Anticipated Number of Awards

Approximately five awards will be issued under this program announcement.

Period of Performance

The period of performance is for 2 years.

Cooperative Agreement

Cooperative agreements awarded by the Department of Health and Human Services (HHS) are administered under the same policies as grants. However, the funding agency, IHS, is anticipated to have substantial programmatic involvement in the project during the entire period of performance. Below is a detailed description of the level of involvement required of the IHS.

Substantial Agency Involvement Description for Cooperative Agreement

A. The IHS Office of Clinical and Preventive Services (OCPS), Division of Clinical and Community Services (DCCS), will collaborate with recipients throughout the process of planning and implementation and assist in the identification of tools, resources, reports, and presentations for dissemination to other Tribal, the IHS, and urban programs. The DCCS will also provide technical assistance in developing a sustainability plan.

B. The IHS will convene recipients periodically, not more often than monthly, to share ideas, strategies, and tools to accelerate design and implementation progress.

C. DCCS will link recipients with Federal agencies and non-governmental organizations working to improve the care of persons living with dementia and their caregivers.

D. DCCS will coordinate reporting (*e.g.,* identified metrics utilized, achieved goals, identified best practices, etc.) and technical assistance (*e.g.,* programmatic support to Tribal communities) as required.

III. Eligibility Information

1. Eligibility

To be eligible under this announcement, an applicant must be one of the following, as defined by 25 U.S.C. 1603:

- A federally recognized Indian Tribe as defined by 25 U.S.C. 1603(14). The term ''Indian Tribe'' means any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 stat. 688) [43 U.S.C. 1601 *et seq.*], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
- A Tribal organization as defined by 25 U.S.C. 1603(26). The term ''Tribal organization'' has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304(1)): ''Tribal organization'' means the recognized governing body of any Indian Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: provided that, in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian Tribe, the approval of each such Indian Tribe shall be a prerequisite to the letting or making of such contract or grant. Applicant shall submit letters of support and/or Tribal Resolutions from the Tribes to be served.
- An Urban Indian organization as defined by 25 U.S.C. 1603(29). The term ''Urban Indian organization'' means a nonprofit 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). Applicants must provide proof of non-profit status with the application, *e.g.,* 501(c)(3).

The program office will notify any applicants deemed ineligible.

Note: Please refer to Section IV.2 (Application and Submission Information/Subsection 2, Content and Form of Application Submission) for additional proof of applicant status documents required, such as Tribal Resolutions, proof of non-profit status, etc.

2. Cost Sharing or Matching

The IHS does not require matching funds or cost sharing for grants or cooperative agreements.

3. Other Requirements

Applications with budget requests that exceed the highest dollar amount outlined under Section II Award Information, Estimated Funds Available, or exceed the period of performance outlined under Section II Award Information, Period of Performance, are considered not responsive and will not be reviewed. The Division of Grants Management (DGM) will notify the applicant.

Tribal Resolution

The DGM must receive an official, signed Tribal Resolution prior to issuing a Notice of Award (NoA) to any Tribe or Tribal organization selected for funding. An applicant that is proposing a project affecting another Indian Tribe must include resolutions from all

affected Tribes to be served. However, if an official, signed Tribal Resolution cannot be submitted with the application prior to the application deadline date, a draft Tribal Resolution must be submitted with the application by the deadline date in order for the application to be considered complete and eligible for review. The draft Tribal Resolution is not in lieu of the required signed resolution but is acceptable until a signed resolution is received. If an application without a signed Tribal Resolution is selected for funding, the applicant will be contacted by the Grants Management Specialist (GMS) listed in this funding announcement and given 90 days to submit an official, signed Tribal Resolution to the GMS. If the signed Tribal Resolution is not received within 90 days, the award will be forfeited.

Tribes organized with a governing structure other than a Tribal council may submit an equivalent document commensurate with their governing organization.

IV. Application and Submission Information

1. Obtaining Application Materials

The application package and detailed instructions for this announcement are available at *https://www.Grants.gov.*

Please direct questions regarding the application process to Mr. Paul Gettys at (301) 443–2114 or (301) 443–5204.

2. Content and Form Application Submission

Mandatory documents for all applicants include:

- Abstract (one page) summarizing the project.
- Application forms:

1. SF–424, Application for Federal Assistance.

2. SF–424A, Budget Information—Non-Construction Programs.

3. SF–424B, Assurances—Non-Construction Programs.

- Project Narrative (not to exceed 10 pages). See Section IV.2.A, Project Narrative for instructions.

1. Background information on the organization.

2. Proposed scope of work, objectives, and activities that provide a description of what the applicant plans to accomplish.

- Budget Justification and Narrative (not to exceed five pages). See Section IV.2.B, Budget Narrative for instructions.
- One-page Timeframe Chart.
- Tribal Resolution(s), if applicable.
- Letters of Support from organization's Board of Directors (optional).
- 501(c)(3) Certificate, if applicable.
- Biographical sketches for all Key Personnel.
- Contractor/Consultant resumes or qualifications and scope of work.
- Disclosure of Lobbying Activities (SF–LLL), if applicant conducts reportable lobbying.
- Certification Regarding Lobbying (GG-Lobbying Form).
- Copy of current Negotiated Indirect Cost (IDC) rate agreement (required in order to receive IDC).
- Organizational Chart.
- Documentation of current Office of Management and Budget (OMB) Financial Audit (if applicable).

Acceptable forms of documentation include:

1. Email confirmation from Federal Audit Clearinghouse (FAC) that audits were submitted; or

2. Face sheets from audit reports. Applicants can find these on the FAC website at *https://facdissem.census.gov/*.

Public Policy Requirements

All Federal public policies apply to IHS grants and cooperative agreements. Pursuant to 45 CFR 80.3(d), an individual shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by Federal law to individuals eligible for benefits and services from the IHS. See *https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html.*

Requirements for Project and Budget Narratives

A. Project Narrative

This narrative should be a separate document that is no more than 10 pages and must: (1) Have consecutively numbered pages; (2) use black font 12 points or larger (applicants may use 10 point font for tables); (3) be single-spaced; and (4) be formatted to fit standard letter paper (8–1/2 x 11 inches).

Be sure to succinctly answer all questions listed under the evaluation criteria (refer to Section V.1, Evaluation Criteria) and place all responses and required information in the correct section noted below or they will not be considered or scored. If the narrative exceeds the page limit, the application will be considered not responsive and will not be reviewed. The 10-page limit for the narrative does not include the work plan, standard forms, Tribal Resolutions, budget, budget justifications, narratives, and/or other items.

There are three parts to the narrative: Part 1—Program Information; Part 2—Program Planning and Evaluation; and Part 3—Sharing with Other Tribes, Tribal Organizations, and Urban Indian Organizations. See below for additional details about what must be included in the narrative.

The page limits below are for each narrative and budget submitted.

Part 1: Program Information (Limit—4 Pages)

Section 1: Tribal or Organizational Overview

Provide a brief description of the Tribe, Tribal organization, or Urban Indian health program, health care delivery system and resources, elderly services and resources, long-term services and supports, and other Tribal or community-based services that might be involved.

Section 2: Needs

Provide any data available about the number of persons living with dementia and their needs and the needs of their caregivers. If data is not currently available, indicate this here and in Part 2 below, and describe in detail how the applicant will obtain or develop this data in the first year of the program.

Section 3: Other Funded Initiatives

Provide information about other funded initiatives addressing dementia that the applicant is or will be participating in that are relevant to this proposal. Indicate any HHS grants addressing dementia (*e.g.* Dementia Capability in Indian Country Grant program of the Administration for Community Living) the applicant has been awarded whose period of performance may overlap the period of performance of this grant opportunity.

Part 2: Program Planning and Evaluation (Limit—4 Pages)

Section 1: Program Plans

Describe fully and clearly the applicant's plan to implement a comprehensive approach to care and services for persons living with dementia and their caregivers and identify funding streams that will support service delivery. The plan should include a vision for a comprehensive approach to care, recognizing that achievement of the fully implemented approach may not be feasible within the period of performance.

Section 2: Program Evaluation

Describe fully and clearly the elements of the comprehensive approach to care described in Section 1 that the applicant expects to implement

over the period of performance. Describe the metrics that will be used to assess the achievement of these goals. If the applicant will need to obtain or develop data about the number of persons living with dementia and their needs and the needs of their caregivers as an element of this award, the applicant should indicate that data and describe how that data will be developed or acquired in the first year.

Part 3: Sharing With Other Tribes, Tribal Organizations, and Urban Indian Organizations (Limit—2 Pages)

Section 1

Describe how your program will develop, in collaboration with the IHS, best and promising practices that includes tools, resources, reports, and presentations, accessible to stakeholders across the Tribal health system including Tribal and urban health partners.

B. Budget Narrative (Limit—5 Pages)

Provide a budget narrative that explains the amounts requested for each line item of the budget from the SF–424A (Budget Information for Non-Construction Programs). The budget narrative can include a more detailed spreadsheet than is provided by the SF–424A. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Be very careful about showing how each item in the ''Other'' category is justified. For subsequent budget years (see Multi-Year Project Requirements in Section V.1, Application Review Information, Evaluation Criteria), the narrative should highlight the changes from year 1 or clearly indicate that there are no substantive budget changes during the period of performance. Do NOT use the budget narrative to expand the project narrative.

3. Submission Dates and Times

Applications must be submitted through *Grants.gov* by 11:59 p.m. Eastern Time on the Application Deadline Date. Any application received after the application deadline will not be accepted for review. *Grants.gov* will notify the applicant via email if the application is rejected.

If technical challenges arise and assistance is required with the application process, contact *Grants.gov* Customer Support (see contact information at *https://www.Grants.gov*). If problems persist, contact Mr. Paul Gettys (*Paul.Gettys@ihs.gov*), Deputy Director, DGM, by telephone at (301) 443–2114 or (301) 443–5204. Please be sure to contact Mr. Gettys at least 10 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.

The IHS will not acknowledge receipt of applications.

4. Intergovernmental Review

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

5. Funding Restrictions

- Pre-award costs are allowable up to 90 days before the start date of the award provided the costs are otherwise allowable if awarded. Pre-award costs are incurred at the risk of the applicant.
- The available funds are inclusive of direct and indirect costs.
- Only one cooperative agreement may be awarded per applicant.

6. Electronic Submission Requirements

All applications must be submitted via *Grants.gov*. Please use the *https://www.Grants.gov* website to submit an application. Find the application by selecting the ''Search Grants'' link on the homepage. Follow the instructions for submitting an application under the Package tab. No other method of application submission is acceptable.

If the applicant cannot submit an application through *Grants.gov*, a waiver must be requested. Prior approval must be requested and obtained from Mr. Paul Gettys, Deputy Director, DGM. A written waiver request must be sent to *GrantsPolicy@ihs.gov* with a copy to *Paul.Gettys@ihs.gov.* The waiver request must: (1) Be documented in writing (emails are acceptable) before submitting an application by some other method; and (2) include clear justification for the need to deviate from the required application submission process.

Once the waiver request has been approved, the applicant will receive a confirmation of approval email containing submission instructions. A copy of the written approval must be included with the application that is submitted to the DGM. Applications that are submitted without a copy of the signed waiver from the Acting Director of the DGM will not be reviewed. The Grants Management Officer of the DGM will notify the applicant via email of this decision. Applications submitted under waiver must be received by the DGM no later than 5:00 p.m. Eastern Time on the Application Deadline Date. Late applications will not be accepted for processing. Applicants that do not register for both the System for Award Management (SAM) and *Grants.gov* and/or fail to request timely assistance with technical issues will not be considered for a waiver to submit an application via alternative method.

Please be aware of the following:

- Please search for the application package in *https://www.Grants.gov* by entering the Assistance Listing (CFDA) number or the Funding Opportunity Number. Both numbers are located in the header of this announcement.
- If you experience technical challenges while submitting your application, please contact *Grants.gov* Customer Support (see contact information at *https://www.Grants.gov*).
- 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 a waiver from the agency must be obtained.
- Applicants are strongly encouraged not to wait until the deadline date to begin the application process through *Grants.gov* as the registration process for SAM and *Grants.gov* could take up to 20 working days.
- Please follow the instructions on *Grants.gov* to include additional documentation that may be requested by this funding announcement.
- Applicants must comply with any page limits described in this funding announcement.
- After submitting the application, the applicant will receive an automatic acknowledgment from *Grants.gov* that contains a *Grants.gov* tracking number. The IHS will not notify the applicant that the application has been received.

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

Applicants and grantee organizations are required to obtain a DUNS number and maintain an active registration in the SAM database. The DUNS number is a unique 9-digit identification number provided by D&B that uniquely identifies each 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, please access the request service through *https://fedgov.dnb.com/webform,* or call (866) 705–5711.

The Federal Funding Accountability and Transparency Act of 2006, as amended (''Transparency Act''), requires all HHS recipients to report information on sub-awards. Accordingly, all IHS recipients 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. This requirement ensures the use of a universal identifier to enhance the quality of information available to the public pursuant to the Transparency Act.

System for Award Management (SAM)

Organizations that are not registered with SAM must have a DUNS number first, then access the SAM online registration through the SAM home page at *https://sam.gov* (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). Please see *SAM.gov* for details on the registration process and timeline. Registration with the SAM is free of charge but can take several weeks to process. Applicants may register online at *https://sam.gov.*

Additional information on implementing the Transparency Act, including the specific requirements for DUNS and SAM, are available on the DGM Grants Management, Policy Topics web page at *https://www.ihs.gov/dgm/policytopics/.*

V. Application Review Information

Possible points assigned to each section are noted in parentheses. The project narrative and budget narrative should include only the first year of activities; information for multi-year projects should be included as a separate document. See ''Multi-year Project Requirements'' at the end of this section for more information. The project narrative should be written in a manner that is clear to outside reviewers unfamiliar with prior related activities of the applicant. It should be well organized, succinct, and contain all information necessary for reviewers to fully understand the project. Attachments requested in the criteria do not count toward the page limit for the narratives. Points will be assigned to each evaluation criteria adding up to a total of 100 possible points. Points are assigned as follows:

1. Evaluation Criteria

A. Introduction and Need for Assistance (10 Points)

1. Description of the clinical services, elder services and resources, long-term care services, and supports available through the applicant's organization, either as a direct service or through agreement, contract, or Purchased and Referred Care (PRC). Applicants must be able to provide ambulatory care services directly or through coordination with IHS Direct Services and must be able to coordinate with elder services.

2. Description of the number of individuals living with dementia to be served, any data available about the prevalence of risk factors for dementia (including age as reflected in the population's demographics), and any limitations of the data available.

3. Identification of the most urgent and pressing gaps in availability or quality of care and services for persons living with dementia and their families. If this information is not available, the acquisition of this information should be a detailed part of the Project Objective(s), Work Plan, and Approach.

4. If the applicant is the recipient of other HHS grants that will provide funding to address dementia over the same time period (*e.g.* Dementia Capability in Indian Country Grant program of the Administration for Community Living), address how funding under this opportunity will address the need without overlapping the activities of other funded awards, if applicable.

B. Project Objective(s), Work Plan, and Approach (30 Points)

1. The overall vision for a comprehensive approach to care and services for persons living with dementia and their caregivers, including:

- Awareness and recognition.
- Timely and accurate diagnosis.
- Multidisciplinary assessment.
- Management and referral.
- Caregiver Support.

2. The elements of this vision that the awardee anticipates implementing, including planning activities and assessment of need, if not already available.

3. The work plan and approach, including planning activities and assessment of need, if not already available. This work plan should be responsive to the most urgent and pressing gaps in availability and quality of care and services for persons living with dementia and their families. This work plan must include, at the minimum, both the provision of clinical services, either directly or through coordination with IHS Direct Services, and the engagement of elder services.

4. The work plan and approach should include developing tools, resources, reports, and presentations to support the development of programs by other Tribes, Tribal organizations, or Urban Indian health programs.

5. If the applicant is the recipient of other HHS grants that will provide funding to address dementia over the same time period (*e.g.* Dementia Capability in Indian Country Grant program of the Administration for Community Living), indicate how the work plan and approach supported through this funding will complement and not supplant or overlap that already-funded work.

C. Program Evaluation (30 Points)

1. Clearly identify plans for program evaluation to ensure that objectives of the program are met at the conclusion of the period of performance.

2. Include SMART (Specific, Measurable, Achievable, Relevant and Time-based) goals to establish a specific set of evaluation criteria to ensure the objectives are attainable within the period of performance.

3. Evaluation should minimally include metrics that provide insight into the implementation of those elements of a comprehensive approach to care and services for persons living with dementia and their families that the applicant has proposed to implement. The evaluation should also include metrics for important outcomes of care for persons living with dementia and their family, such as avoidance of crisis-driven care (*e.g.* emergent transfers and undesired out-of-home placement) as well as processes of care that contribute to better outcomes (*e.g.* reduction of medications that impair cognition).

D. Organizational Capabilities, Key Personnel, and Qualifications (20 Points)

1. Include an organizational capacity statement that demonstrates the ability to execute program strategies within the period of performance.

2. Project management and staffing plan. Detail that the organization has the current staffing and expertise to address each of the program activities. If capacity does not exist, please describe the applicant's actions to fulfill this gap within a specified timeline.

3. Identify any partnerships or collaborations that will be needed to implement the work plan and include letters of support or intent to coordinate or collaborate with those partners.

4. Demonstrate that the applicant has previous successful experience providing technical or programmatic support to Tribal communities.

E. Categorical Budget and Budget Justification (10 Points)

1. Provide a detailed budget and accompanying narrative to explain the activities being considered and how they are related to proposed program objectives.

Multi-Year Project Requirements

Applications must include a brief project narrative and budget (one additional page per year) addressing the developmental plans for each additional year of the project. This attachment will not count as part of the project narrative or the budget narrative.

Additional documents can be uploaded as Other Attachments in *Grants.gov*. These can include:

- Work plan, logic model and/or timeline for proposed objectives.
- Position descriptions for key staff.
- Resumes of key staff that reflect current duties.
- Consultant or contractor proposed scope of work and letter of commitment (if applicable).
- Current Indirect Cost Rate Agreement.
- Organizational chart.
- Map of area identifying project location(s).
- Additional documents to support narrative (*i.e.* data tables, key news articles, etc.).

2. Review and Selection

Each application will be prescreened for eligibility and completeness as outlined in the funding announcement. Applications that meet the eligibility criteria shall be reviewed for merit by the Objective Review Committee (ORC) based on evaluation criteria. Incomplete applications and applications that are not responsive to the administrative thresholds (budget limit, project period limit) will not be referred to the ORC and will not be funded. The applicant will be notified of this determination.

Applicants must address all program requirements and provide all required documentation.

3. Notifications of Disposition

All applicants will receive an Executive Summary Statement from the IHS DCCS within 30 days of the conclusion of the ORC outlining the strengths and weaknesses of their application. The summary statement will be sent to the Authorizing Official identified on the face page (SF–424) of the application.

A. Award Notices for Funded Applications

The NoA is the authorizing document for which funds are dispersed to the approved entities and reflects the amount of Federal funds awarded, the purpose of the award, the terms and conditions of the award, the effective date of the award, and the budget/project period. Each entity approved for funding must have a user account in GrantSolutions in order to retrieve the NoA. Please see the Agency Contacts list in Section VII for the systems contact information.

B. Approved but Unfunded Applications

Approved applications not funded due to lack of available funds will be held for 1 year. If funding becomes available during the course of the year, the application may be reconsidered.

Note: Any correspondence other than the official NoA executed by an IHS grants management official announcing to the project director that an award has been made to their organization is not an authorization to implement their program on behalf of the IHS.

VI. Award Administration Information

1. Administrative Requirements

Awards issued under this announcement are subject to, and are administered in accordance with, the following regulations and policies:

A. The Criteria as Outlined in This Program Announcement

B. Administrative Regulations for Grants

- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards currently in effect or implemented during the period of award, other Department regulations and policies in effect at the time of award, and applicable statutory provisions. At the time of publication, this includes 45 CFR part 75, at *https://www.govinfo.gov/content/pkg/CFR-2020-title45-vol1/pdf/CFR-2020-title45-vol1-part75.pdf.*
- Please review all HHS regulatory provisions for Termination at 45 CFR 75.372, at *https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&SID=2970eec67399fab1413ede53d7895d99&mc=true&n=pt45.1.75&r=PART&ty=HTML&se45.1.75_1372#se45.1.75_1372.*

C. Grants Policy

- HHS Grants Policy Statement, Revised January 2007, at *https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.*

D. Cost Principles

- Uniform Administrative Requirements for HHS Awards, ''Cost Principles,'' located at 45 CFR part 75 subpart E.

E. Audit Requirements

- Uniform Administrative Requirements for HHS Awards, ''Audit Requirements,'' located at 45 CFR part 75 subpart F.

F. As of August 13, 2020, 2 CFR 200 was updated to include a prohibition on certain telecommunications and video surveillance services or equipment. This prohibition is described in 2 CFR 200.216. This will also be described in the terms and conditions of every IHS grant and cooperative agreement awarded on or after August 13, 2020.

2. Indirect Costs

This section applies to all recipients that request reimbursement of IDC in their application budget. In accordance with HHS Grants Policy Statement, Part II–27, the IHS requires applicants to obtain a current IDC rate agreement, and submit it to the DGM prior to the DGM issuing an 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 agreement is not on file with the DGM at the time of award, the IDC portion of the budget will be restricted. The restrictions remain in place until the current rate agreement is provided to the DGM.

Per 45 CFR 75.414(f) Indirect (F&A) costs, ''any non-Federal entity (NFE) [*i.e.,* applicant] that has never received a negotiated indirect cost rate, . . . may elect to charge a de minimis rate of 10 percent of modified total direct costs which may be used indefinitely. As described in Section 75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as the NFE chooses to negotiate for a rate, which the NFE may apply to do at any time.''

Electing to charge a de minimis rate of 10 percent only applies to applicants that have never received an approved negotiated indirect cost rate from HHS or another cognizant federal agency. Applicants awaiting approval of their indirect cost proposal may request the 10 percent de minimis rate. When the applicant chooses this method, costs included in the indirect cost pool must not be charged as direct costs to the grant.

Available funds are inclusive of direct and appropriate indirect costs. Approved indirect funds are awarded as part of the award amount, and no additional funds will be provided.

Generally, IDC rates for IHS recipients are negotiated with the Division of Cost Allocation at *https://rates.psc.gov/* or the Department of the Interior (Interior

Business Center) at *https://ibc.doi.gov/ICS/tribal.* For questions regarding the indirect cost policy, please call the Grants Management Specialist listed under ''Agency Contacts'' or the main DGM office at (301) 443–5204.

3. Reporting Requirements

The grantee must submit required reports consistent with the applicable deadlines. Failure to submit required reports within the time allowed may result in suspension or termination of an active grant, 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 the imposition of special award provisions, and/or the non-funding or non-award of other eligible projects or activities. This requirement applies whether the delinquency is attributable to the failure of the awardee organization or the individual responsible for preparation of the reports. Per DGM policy, all reports must be submitted electronically by attaching them as a ''Grant Note'' in GrantSolutions. Personnel responsible for submitting reports will be required to obtain a login and password for GrantSolutions. Please see the Agency Contacts list in Section VII for the systems contact information.

The reporting requirements for this program are noted below.

A. Progress Reports

Program progress reports are required semi-annually. The progress reports are due within 30 days after the reporting period ends (specific dates will be listed in the NoA Terms and Conditions). These reports must include a brief comparison of actual accomplishments to the goals established for the period, a summary of progress to date or, if applicable, provide sound justification for the lack of progress, and other pertinent information as required. A final report must be submitted within 90 days of expiration of the period of performance.

B. Financial Reports

Federal Cash Transaction Reports are due 30 days after the close of every calendar quarter to the Payment Management Services at *https://pms.psc.gov.* Failure to submit timely reports may result in adverse award actions blocking access to funds.

Federal Financial Reports are due 30 days after the end of each budget period, and a final report is due 90 days after the end of the Period of Performance.

Recipients are responsible and accountable for reporting accurate information on all required reports: The Progress Reports, the Federal Cash Transaction Report, and the Federal Financial Report.

C. Data Collection and Reporting

The grantee will participate in periodic (not more frequently than monthly) web-based calls with the program office or designee and the other recipients to share their progress, experience, and tools and resource that might be useful for other recipients. The grantee will be expected to work with the program office to develop a driver diagram (an action-oriented logic model) that describes the comprehensive approach to care and services for persons living with dementia and their caregivers and identifies key performance metrics based on their evaluation plan.

The grantee will be expected to share, on a semi-annual basis, the tools, resources, reports, and presentations produced that may support the development of programs by other Tribes, Tribal organizations, or Urban Indian health programs.

D. Federal Sub-Award Reporting System (FSRS)

This award may be subject to the Transparency Act sub-award and executive compensation reporting requirements of 2 CFR part 170.

The 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 sub-awards and executive compensation under Federal assistance awards.

The IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs, and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $25,000 sub-award obligation threshold met for any specific reporting period.

For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Management website at *https://www.ihs.gov/dgm/policytopics/.*

E. Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance

Should you successfully compete for an award, recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes ensuring programs are accessible to persons with limited English proficiency and persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. Please see *https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html* and *https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.*

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficiency individuals, see *https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html* and *https://www.lep.gov.*
- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, see *https://www.hhs.gov/civil-rights/for-individuals/disability/index.html.*
- HHS funded health and education programs must be administered in an environment free of sexual harassment. See *https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.*
- For guidance on administering your program in compliance with applicable Federal religious nondiscrimination laws and applicable Federal conscience protection and associated anti-discrimination laws, see *https://www.hhs.gov/conscience/conscience-protections/index.html* and *https://www.hhs.gov/conscience/religious-freedom/index.html.*

F. Federal Awardee Performance and Integrity Information System (FAPIIS)

The IHS is required to review and consider any information about the applicant that is in the FAPIIS, at *https://www.fapiis.gov/fapiis/#/home*

before making any award in excess of the simplified acquisition threshold (currently $250,000) over the period of performance. An applicant may review and comment on any information about itself that a Federal awarding agency previously entered. The IHS will consider any comments by the applicant, in addition to other information in FAPIIS, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants as described in 45 CFR 75.205.

As required by 45 CFR part 75 appendix XII of the Uniform Guidance, NFEs are required to disclose in FAPIIS any information about criminal, civil, and administrative proceedings, and/or affirm that there is no new information to provide. This applies to NFEs that receive Federal awards (currently active grants, cooperative agreements, and procurement contracts) greater than $10,000,000 for any period of time during the period of performance of an award/project.

Mandatory Disclosure Requirements

As required by 2 CFR part 200 of the Uniform Guidance, and the HHS implementing regulations at 45 CFR part 75, the IHS must require an NFE or an applicant for a Federal award to disclose, in a timely manner, in writing to the IHS or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

All applicants and recipients must disclose in writing, in a timely manner, to the IHS and to the HHS Office of Inspector General all information related to violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. 45 CFR 75.113.

Disclosures must be sent in writing to:

U.S. Department of Health and Human Services, Indian Health Service, Division of Grants Management, ATTN: Paul Gettys, Deputy Director, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857 (Include ''Mandatory Grant Disclosures'' in subject line), Office: (301) 443–5204, Fax: (301) 594–0899, Email: *Paul.Gettys@ihs.gov*

And

U.S. Department of Health and Human Services, Office of Inspector General, ATTN: Mandatory Grant Disclosures, Intake Coordinator, 330 Independence Avenue SW, Cohen Building, Room 5527, Washington, DC 20201, URL: *https://oig.hhs.gov/fraud/report-fraud/* (Include ''Mandatory Grant Disclosures'' in subject line), Fax: (202) 205–0604 (Include ''Mandatory Grant Disclosures'' in subject line), or Email: *MandatoryGranteeDisclosures@oig.hhs.gov*

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 Remedies for noncompliance, including suspension or debarment (see 2 CFR part 180 and 2 CFR part 376).

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to: Dr. Marcy Ronyak, Director, DCCS, Office of Clinical and Preventive Services, Division of Clinical and Community Services, Indian Health Service, 5600 Fishers Lane, Mailstop: 08N34–A, Rockville, MD 20857, Phone: (301) 443–6458, Fax: (301) 594–6213, Email: *Marcella.Ronyak@ihs.gov*.

2. Questions on grants management and fiscal matters may be directed to: Donald Gooding, Grants Management Specialist, Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2298, Email: *Donald.Gooding@ihs.gov.*

3. Questions on systems matters may be directed to: Paul Gettys, Deputy Director, Division of Grants Management, Indian Health Service, Division of Grants Management, 5600 Fishers Lane, Mail Stop: 09E70, Rockville, MD 20857, Phone: (301) 443–2114; or the DGM main line (301) 443–5204, Email: *Paul.Gettys@ihs.gov.*

VIII. Other Information

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

Elizabeth A. Fowler,

Acting Director, Indian Health Service.

[FR Doc. 2022–08249 Filed 4–15–22; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lung, and Blood Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Heart, Lung, and Blood Institute Special Emphasis Panel; Phase II SBIR Topic 107.

Date: May 24, 2022.

Time: 9:30 a.m. to 11:30 a.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health, 6705 Rockledge Drive, Bethesda, MD 20817 (Virtual Meeting).

Contact Person: Rajiv Kumar, Ph.D., Branch Chief, Blood and Vascular Branch, Office of Scientific Review, National Heart, Lung and Blood Institute, National Institutes of Health, 6705 Rockledge Drive, Room 208–W, Bethesda, MD 20892, (301) 435–0270, *rajiv.kumar@nih.gov*.

Name of Committee: National Heart, Lung, and Blood Institute Special Emphasis Panel; Systems Biology and Pulmonary Disease.

Date: May 27, 2022.

Time: 12:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Shelley S. Sehnert, Ph.D., Scientific Review Officer, Office of Scientific Review/DERA, National Heart, Lung, and Blood Institute, National Institutes of Health, 6705 Rockledge Drive, Room 208–T, Bethesda, MD 20892–7924, (301) 827–7984, *ssehnert@nhlbi.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.233, National Center for Sleep Disorders Research; 93.837, Heart and Vascular Diseases Research; 93.838, Lung Diseases Research; 93.839, Blood Diseases and Resources Research, National Institutes of Health, HHS)

Dated: April 12, 2022.

David W. Freeman,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–08202 Filed 4–15–22; 8:45 am]

BILLING CODE 4140–01–P