**OMB Clearance Number: 2528-0337**
**Expires: XX/XX/XXXX**

**Supporting Statement for Paperwork Reduction Act Submissions**
**The Community Choice Demonstration**
**(OMB #** 2528-0337**)**

## A. Justification

### 1. Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.

The Office of Policy Development and Research (PD&R), at the U.S. Department of Housing and Urban Development (HUD), is seeking approval to collect additional information of individuals participating in the Community Choice Demonstration (formerly known as the Housing Choice Voucher Mobility Demonstration) ("Demonstration" for short). The instruments required for the implementation and early phase of the evaluation of the Demonstration were originally approved by the OMB in May and June 2022. Approval was granted under OMB Control #2528-0337 and expires June 30, 2025.

The Demonstration is a once-in-a-generation opportunity to build rigorous evidence on how to advance the long-held goals of expanding residential choice and facilitating moves to lower poverty areas by Housing Choice Voucher (HCV) families. This information collection request seeks approval to expand the previously approved Demonstration to include three additional assessments. The additional assessments involved in this revised data collection include a Home Assessment, a Child Assessment, and an Obesity and Type II Diabetes Risk Assessment. These assessments will focus on understanding the effects of being offered mobility-related services on the physical and mental health and health behavior of a subset of adults and children participating in the Demonstration. Although the CCD study was not originally designed to examine improvements in child health, these additional assessments provide an opportunity to do so. The Home Assessment and Child Assessment are funded by HUD. The Obesity and Type II Diabetes Risk Assessment is funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)[1]and led by Johns Hopkins University (JHU) as part of a study called the Mobility Opportunity Vouchers for Eliminating Disparities (MOVED). HUD's contract with Abt Associates for the CCD evaluation provides flexibility to explore collaborations with other researchers and funders to support additional knowledge-building efforts that build on the foundation laid by the Demonstration so long as they advance important research objectives, do not interfere with the core Demonstration and are structured in a way that minimizes overall respondent burden. The Obesity and Type II Diabetes Risk Assessment represents one such collaboration.

[1] The NIDDK grant number is R01DK136610.

## Demonstration Overview

The Consolidated Appropriations Act, 2019 (Pub. L. 116-6) and the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) authorized HUD to implement and evaluate the Demonstration. As described in the Federal Register Notice Docket Number FR-6191-N-01, HUD is implementing a multi-site randomized controlled trial (RCT) to test and evaluate the effectiveness of the Demonstration. The primary purposes of the Demonstration are to provide voucher assistance and mobility-related services to families with children to encourage such families to move to lower-poverty areas, to expand their access to opportunity areas, and to evaluate the effectiveness of the strategies pursued under the Demonstration. These neighborhoods which the Demonstration calls "opportunity areas" have been designated by the evaluation contractor with input from HUD and the participating public housing agencies (PHAs) and were chosen based on several area indicators including family poverty rate, share of rental units occupied by HUD-assisted families with children, percentile on key opportunity indices (Child Opportunity Index percentile and Opportunity Atlas), and test scores of nearby elementary schools.

Eight sites around the U.S. (which include 10 PHAs) are participating in the Demonstration[2] by offering mobility-related services to eligible families with children.[3] Both existing families with vouchers ("existing voucher families") and families newly offered a voucher from the waiting list ("waitlist families") are eligible to participate. Participating PHAs have adopted administrative policies that further enable housing mobility, increase landlord participation, and reduce barriers for families to move across PHA jurisdictions through portability.[4] Eligible families that consent to participate in the Demonstration are being randomly assigned to either receive mobility-related services or to not receive mobility-related services.

The Demonstration seeks to enroll approximately 15,250 families over a five-year enrollment period—of which approximately 14,350 will be existing voucher families and approximately 900 will be waitlist families. Enrollment will occur in two phases. During the first two years of enrollment (Phase 1), the Demonstration will randomly assign approximately 5,100 families to either (a) a single treatment group or (b) a control group that will not receive any mobility-related services. The treatment group will be offered a comprehensive set of mobility-related services (CMRS). During the following three years of enrollment (Phase 2), beginning in fall of 2024, the Demonstration will add a second treatment group, selected mobility-related services (SMRS). During Phase 2, families will be randomly assigned to one of three groups: (a) a group offered CMRS, (b) a group offered SMRS, or (c) the control group that will not receive any mobility-related services. Phase 1 of the study is evaluating whether the offer of CMRS helps families with children access and remain in opportunity areas and exploring which services

[2] A list of the participating PHAs can be accessed here: https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/mobilitydemo

[3] For the purpose of this Demonstration, eligible families are defined as households consisting of at least one adult and one child aged 17 or under.

[4] In the context of the Housing Choice Voucher program, portability refers to the process of moving from the jurisdiction of one PHA to the jurisdiction of another PHA. For more information, see https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/portability

appear to be most effective and cost-effective. Phase 2 will evaluate the effectiveness of SMRS and compare the outcomes of CMRS and SMRS. All families will receive standard services offered through the Housing Choice Voucher program, and those assigned to the CMRS or SMRS group will receive mobility-related services. Effectiveness is measured by whether families move to opportunity areas and whether they stay in those areas (up to two years after random assignment).

This Information Collection Request (ICR) seeks approval for additional data collection that begins during Phase 1 and extends into Phase 2. The assessments will be limited to families in the group offered CMRS and the control group.

PD&R has contracted with Abt Associates to lead the evaluation. Abt Associates will also be collecting the data for the Home Assessment, the Child Assessment and the Obesity and Type II Diabetes Risk Assessment. Windjammer Environmental will provide technical expertise on the Home Assessment data collection.

**Research Questions**

Through these three new assessments, HUD has designed the Demonstration to answer a number of vital questions. Each assessment has its own research questions. The effect of *offering* CMRS rather than *using* CMRS services is examined in several research questions because this approach provides the most rigorous way to measure the effect of an intervention, without bias contributed by personal characteristics that could influence participant "take-up" or level of involvement in the services that are offered. This strategy is known as an intent-to-treat (ITT) approach and is the standard for impact analyses using experimental design. Although the treatment on the treated (TOT) will also be estimated, the ITT is of particular relevance because the offer of a program is the component that the study design can control, whereas the study design cannot control for or determine who will choose to accept the offer of the program or how much they will utilize the services. As a result, the ITT provides the more conservative but more robust estimate of an intervention's impact.

*Home Assessment*

The research questions motivating the Home Assessment study are:

HA-1. For voucher families with children, what is the effect of offering CMRS on levels of exposure to indoor pollutants and allergens?

HA-2. For voucher families with children, what is the effect of offering CMRS on self-reported health conditions or symptoms related to indoor air quality and exposure to allergens (e.g., exacerbation of asthma or other respiratory issues)?

HA-3. For voucher families with children, to what extent are residences in opportunity areas associated with lower levels of exposure to indoor pollutants and allergens?

HA-4. For voucher families with children, to what extent are residential moves (regardless of whether the destination is an opportunity area) associated with lower levels of exposure to indoor pollutants and allergens?

*Child Assessment*

The research questions motivating the Child Assessment are:

CA-1. How does the offer of CMRS affect the following domains two years after random assignment? (a) parenting; (b) child executive function; (c) child behavior; (d) child anxiety; (e) child diet and physical activity; and (f) other aspects of child well-being.

CA-2. Does the impact of being offered CMRS on these domains vary by child age or gender?

*The Obesity and Type II Diabetes Risk Assessment*

The research questions motivating the Obesity and Type II Diabetes Risk Assessment are:

OD-1. How does the offer of CMRS affect obesity and type II diabetes risk two years after random assignment compared to the control group among adults and children?

OD-2 What behavioral, psychosocial, structural, and other factors link neighborhoods to obesity and type II diabetes risk?

OD-3. Does the impact of being offered CMRS vary by sociodemographic and other characteristics?

**Data Collection**

To answer the research questions, data will be collected through a variety of methods including direct measurements, interviews, observations, and surveys. Each assessment's procedures are outlined below. Participants will be asked to provide informed consent before any data collection takes place. Participation in the Home Assessment, Child Assessment, and Obesity and Type II Diabetes Risk Assessment is voluntary and households participating in the main Demonstration are not required to participate in any of these additional data collections.

*Home Assessment*

In the Home Assessment, the evaluation contractor will administer data collection at two of the eight Demonstration sites that will involve the heads of household of an estimated 570 families. The heads of households selected to participate in the Home Assessment will be contacted shortly after random assignment in the Demonstration for a baseline Home Assessment. The same data collection will be repeated approximately 12 months later as follow-up. Data collection will include three components:

- **Direct Measurements of pest allergens and indoor air quality in the home**. The direct assessment will assess 1) temperature and relative humidity, 2) carbon dioxide, 3) carbon monoxide, 4) mouse and cockroach allergens, 5) particulate matter, and 6) volatile organic compounds (VOCs—chemicals that enter the air from paints, cleaners, etc.) These pollutants and allergens will serve as indicators of household ventilation, local air pollution, and potential health effect risk as all are important drivers of childhood asthma. The combination of measures of particulate matter and VOCs with responses to survey questions will allow for assessment of cigarette smoke exposure in lieu of conducting more costly and time-consuming nicotine sampling. See attachment D for this instrument.

- **Observations by the Interviewer**. Interviewer observations will focus on risk factors for asthma and respiratory conditions, including sources of indoor air pollutants and allergens, and housing and neighborhood quality. The contractor will record observations about the unit using a brief checklist presented in attachment E.

- **Brief Survey**. The survey will obtain information from the head of household on risk factors for asthma and other respiratory conditions and child health conditions. Survey questions will be used to measure self-reported health outcomes, including whether anyone in the home suffers from respiratory illness or allergies, and whether any medical care was recently sought for these symptoms. An additional series of questions will focus specifically on the occurrence of asthma symptoms. The survey will also collect information on exposure to smoking. Some survey questions will be used to understand potential pollutant sources, such as whether a gas stove in the home has been recently used. See attachment F.1 and F.2.

*Child Assessment*

In the Child Assessment, the evaluation contractor will administer validated child and caregiver assessments at baseline, shortly after random assignment, and a two-year follow-up at three of the eight Demonstration sites (different from those selected for the Home Assessment in order to minimize the burden on responding families). Data will be collected from one randomly selected child and the child's parent or guardian in an estimated 837 families with an eligible child between the ages of 2 and 15 at baseline. These families will be split between families in the group offered CMRS and the control group. All of these families will also participate in the Obesity and Type II Diabetes Risk Assessment, described in more detail below. Data collection will include two components:

- **Survey about child (questions asked of parent or guardian).** The parent or guardian will report on child behavioral and mental health, physical health, social functioning, and education as well as on the caregiving practices of the parent or guardian and the housing environment using validated assessments. See attachment H.1 and H.2.

- **Direct Child Assessment and Survey**. A trained interviewer will administer a brief tablet-based assessment of children's executive functioning for all children. The interviewer will also administer a brief survey to school-aged children. See attachment I.1, I.2, and I.3.

*The Obesity and Type II Diabetes Risk Assessment*

In the Obesity and Type II Diabetes Risk Assessment, the evaluation contractor will administer data collection at baseline and a two-year follow-up at three of eight Demonstration sites (the same sites as the Child Assessment). The data will be collected for 900 families (approximately half of whom will be in the group offered CMRS and the other half will be in the control group) from one parent or guardian and one child. (An estimated 837 of these families, who have an eligible child aged between 2 and 15, will also be participating in the Child Assessment, as described above.) Households that participate in the Obesity and Type II Diabetes Risk Assessment but not the Child Assessment are those that do not have a child that meets the age eligibility.

Data collection at baseline and follow-up will include the following components. Participants will have the option of participating in some or all of these data collection activities:

- **Adult Survey.** The adult will respond to a 60-minute interviewer-administered survey about behavioral, psychosocial, perceived contextual, and structural factors, that are potentially associated with obesity and type II diabetes risk. See Attachment M.1 and M.2
- **Anthropometric Assessment (adult).** The adults will have their height, weight, and waist circumference measured by trained research staff. All measures will be taken three times and averaged. See Attachment N.
- **Anthropometric Assessment (child).** The child will have their height, weight, and waist circumference measured by trained research staff. All measures will be taken three times and averaged. See Attachment O.
- **Blood Spot Sample (adult).** To assess diabetes risk, research staff will collect a blood spot sample from the adult respondent to measure hemoglobin A1c. Each blood spot sample requires only four drops of blood from the fingertip. Participants will be provided with their results and resources should they need or want to follow-up with their healthcare provider. See attachment P.
- **Home Observations/Housing Assessment**. Interviewer observations will focus on home and neighborhood observations that are risk factors for poor health, including factors that impact diet and exercise. The contractor will record observations about the unit using a brief checklist presented in attachment Q.
- **Accelerometers (adult).** A subset of 400 (about half from the group offered CMRS and half from the control group) of the adults will wear an accelerometer, a device-based motion sensor that captures an individual's movement as an objective, continuous measurement of physical activity and sleep, for 7 consecutive days. See Attachment R.
- **Accelerometers (child).** A subset of 400 (about half from the group offered CMRS group and half from the control group) children will wear an accelerometer for 7 consecutive days. See Attachment S.

- **Blood Pressure Readings (adult).** Trained research staff will take blood pressure assessments on a subset of 900 adults to obtain a direct measure of blood pressure which is strongly associated with obesity and diabetes risk and hypothesized to be related to neighborhood change**.** See Attachment T.
- **Semi-Structured Interviews (adult).** Only at follow-up, a subset of 75 adults, 25 from each site (oversampling the treatment group relative to the control group 2:1) will complete a 90-minute semi-structured in-depth interview. The interviews will dive deeper into the factors explored in the survey that are potentially associated with obesity and type II diabetes risk, such as perceived barriers and facilitators to eating a healthy diet, the role of mental health and social support, and exposure to violence. See Attachment V.
- **Tracking Contacts:** Abt Associates will contact families to update their contact information on a quarterly basis beginning in the sixth month after random assignment. Abt Associates will contact each adult who completed a baseline interview to confirm or update their name, address, phone, and email. The individual will also be asked to provide the name, address and phone number of someone who will always know how to reach them. Contacts with these individuals will alternate between phone for one contact and email/text for the next contact.
    - **Tracking Emails/Texts (adult).** Abt Associates will contact the adult by email or text at two points—9 and 15 months after random assignment. These emails/texts will include a link to an online portal for the adults to update their information. These updates are expected to take 8 minutes on average to complete. See Attachment W.
    - **Tracking Calls (adult).** Abt Associates will contact the adult by phone at three points—6, 12, and 18 months after random assignment. These calls will take 10 minutes on average to complete. See Attachment X.

Each assessment leverages the baseline's study randomized experimental framework, which is cognizant of race and other protected classes. The evaluation contractor will conduct balance testing to ensure that characteristics of participants in the treatment and control groups at baseline are statistically equivalent and will apply weights if they are unbalanced so that the analyses yield robust impact estimates. Notably, the study design does allow for isolating the impact of the intervention on child health regardless of historical and geographical differences in health by race because the impact of moving to an opportunity area will be measured for each study participant at the individual level and compared against their baseline health measures.

**Instruments and Attachments**

Below is a list of all attachments, including data collection instruments. All attachments that are data collection instruments are marked with an asterisk.

- The Home Assessment: Flyer (Attachment A.1)
- The Home Assessment: Advance Letter (Attachment A.2)
- The Home Assessment: Email Reminder (Attachment B.1)
- The Home Assessment: Follow-up Phone Call Script (Attachment B.2)
- The Home Assessment: Consent* (Attachment C)

- The Home Assessment: Direct Measurements*(Attachment D)
- The Home Assessment: Interviewer Observations*(Attachment E)
- The Home Assessment: Baseline Survey*(Attachment F.1)
- The Home Assessment: Follow-up Survey*(Attachment F.2)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Assent* (Attachment G)
- The Child Assessment: Survey about Child Baseline (questions asked of parent or guardian)* (Attachment H.1)
- The Child Assessment: Survey about Child Follow-up (questions asked of parent or guardian)* (Attachment H.2)
- The Child Assessment: Direct Child Assessment Baseline* (Attachment I.1)
- The Child Assessment: Direct Child Assessment Follow-up* (Attachment I.2)
- The Child Assessment: Direct Child Assessment Executive Functioning* (Attachment I.3)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Flyer (Attachment J.1)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Advance Letter (Attachment J.2)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Email Reminder (Attachment K.1)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Follow-up Phone Call Script (Attachment K.2)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Consent* (Attachment L)
- The Obesity and Type II Diabetes Risk Assessment: Adult Survey Baseline* (Attachment M.1)
- The Obesity and Type II Diabetes Risk Assessment: Adult Survey Follow-up* (Attachment M.2)
- The Obesity and Type II Diabetes Risk Assessment: Anthropometric Assessments* (adult) (Attachment N)
- The Obesity and Type II Diabetes Risk Assessment: Anthropometric Assessments* (child) (Attachment O)
- The Obesity and Type II Diabetes Risk Assessment: Blood Spot Samples (adult)* (Attachment P)
- The Obesity and Type II Diabetes Risk Assessment: Home Observations/Housing Assessment* (Attachment Q)
- The Obesity and Type II Diabetes Risk Assessment: Accelerometers (adult)* (Attachment R)
- The Obesity and Type II Diabetes Risk Assessment: Accelerometers (child)* (Attachment S)
- The Obesity and Type II Diabetes Risk Assessment: Blood Pressure Readings (adult)* (Attachment T)
- The Obesity and Type II Diabetes Risk Assessment: Semi-Structured Interviews Consent* (Attachment U)
- The Obesity and Type II Diabetes Risk Assessment: Semi-Structured Interviews (adult)* (Attachment V)

- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Tracking Emails/Texts (Attachment W)
- The Child Assessment & The Obesity and Type II Diabetes Risk Assessment: Tracking Calls (Attachment X)

**2. Indicate how, by whom and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.**

**Purpose**

The purpose of the additional assessments is to see whether moving to opportunity areas positively impacts child health. These new assessments will add important information on the impacts of the Demonstration. This information cannot be collected in other ways. The Home Assessment will assess how being offered CMRS to assist with moves to opportunity areas affects exposure to pest allergens and indoor pollutants that may impact health conditions among low-income children. The Child Assessment will assess how being offered CMRS may affect children's conduct problems and physical and mental health. The Obesity and Type II Diabetes Risk Assessment will assess how being offered CMRS affects the risk of obesity and type II diabetes (primarily for the head of household and secondarily for one child in each household). Each of these assessments will leverage the CCD's existing randomized experimental design framework to assess the impact of the overall CCD outcome (moving to opportunity areas) on child health, while adjusting for individual characteristics that may affect outcomes, including unobservable characteristics. The purpose of each data collection activity is described in greater detail below.

*Home Assessment*

Among other changes that can accompany moves to opportunity areas are changes in the home environment that could affect children's exposure to allergens and poor air quality that contribute to flare-ups of their asthma or other respiratory conditions. The Home Assessment will examine the impacts of being offered CMRS on indoor air quality indicators and exposure to cockroach and mouse allergens. Additional descriptive analyses will further explore the relationship between residential moves to opportunity areas and improvements in home air quality, as well as the relationship between all residential moves and improvements in home environmental quality.

*Child Assessment*

Moving to an opportunity area can offer children opportunities that significantly improve their well-being. In their analysis of long-term outcomes for children in the Moving to Opportunity Demonstration, for example, Chetty et al.[5] find improvements in earnings and educational outcomes of young adults who moved to a low-poverty area before age 13. Less is known about the short-term impacts of moving to a lower-poverty neighborhood on children and their parents or guardians. The focus of the Child Assessment is to understand how being offered CMRS

[5] Chetty, R., Hendren, N., & Katz, L. F. (2016). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity experiment. *American Economic Review*, *106*(4), 855–902. https://doi.org/10.1257/aer.20150572

might affect children's well-being in the short term, focusing on outcomes in mental and physical health and behavior and conduct. In doing so, it will collect data to examine both *outcomes* of CMRS – for instance, the effects of CMRS on subsequent child physical health – as well as *mediators* – that is, factors that either facilitate (mediate) or suppress (moderate) any main effect of CMRS. As an example, this analysis will examine parenting practices as a mediator of the relationship between CMRS and subsequent effects on child mental and behavioral health. Parenting practices are hypothesized to mediate the relationship between community disadvantage and child behavioral health. The family stress model[6] theorizes that parental distress can contribute to child behavior problems through disrupted parenting practices. An application of this model to community-based stressors (e.g., concentrated disadvantage and violent crime) finds that these stressors are associated with children's behavior through similar processes of parental distress and parenting.[7] To the extent that improved safety in children's environments reduces parental stress, this model hypothesizes that children would display fewer behavioral problems through increased use of positive parenting practices.

*The Obesity and Type II Diabetes Risk Assessment*

Racial and socioeconomic disparities in obesity and type II diabetes prevalence are well-documented, widespread, and persistent. Lifestyle interventions alone have not eliminated these inequities. Prior research on long-term outcomes of the Moving to Opportunity Demonstration found that being offered the chance to move to a low-poverty neighborhood reduces adult obesity and type II diabetes risk. Less is known about the short-term impacts of moving to a lower-poverty neighborhood on obesity and type II diabetes risk and little is known about the many potential pathways. These pathways are likely varied, potentially impacting dietary intake and physical activity through a range of different mechanisms, including but not limited to changes in stress, different access to food, transportation, and exercise venues, and family routines. These further intersect with the healthcare system and with other aspects of health, such as blood pressure. The focus of the Obesity and Type II Diabetes Risk Assessment is to investigate to what extent being offered CMRS impacts obesity and type II diabetes risk among adults and obesity among children, relative to the control group and use a range of methods to identify potential pathways and spillover effects.

**Who Will Use this Information?**

The evaluation contractor will use the information collected through the Home and Child Assessments to prepare reports to HUD on the findings of the Demonstration. The primary beneficiary of these reports (and the data used to inform the reports) will be HUD. HUD will use the information from the study to understand the impact of mobility-related services on short-term impacts on adults and children who move to an opportunity area on health, mental health, and other outcomes. The findings of the impact analyses for the Home Assessment and the Child Assessment will be published by HUD.

[6] Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the Family Stress Model. *Current Opinion in Psychology*, *13*, 85-90. https://doi.org/10.1016/j.copsyc.2016.05.008

[7] Votruba-Drzal, E., Miller, P., Betancur, L., Spielvogel, B., Kruzik, C., & Coley, R. L. (2021). Family and community resource and stress processes related to income disparities in school-aged children's development. *Journal of Educational Psychology*, *113*(7), 1405. https://doi.org/10.1037/edu0000589

Researchers at Johns Hopkins University will analyze the information collected through the Obesity and Type II Diabetes Risk Assessment as part of the MOVED study and report on the results in one or more peer-reviewed journals; they will use this information to determine the extent to which moving to an opportunity area affects adult and child health.

Findings from the three assessments are relevant to a broad set of policymakers, voucher families, and researchers. Data from all three assessments will also be made available to other interested researchers who agree to required privacy and data security safeguards.

**Instrument Item-by-Item Justification Chart**

Exhibit A.1 lists key information about each instrument and the corresponding attachment on which it appears, as well as its content, and reason or purpose. All respondents are participants who are a part of the Demonstration.

**Exhibit A.1: Item-by-Item Justification Chart**

| Instrument | Content | Reason/Purpose |
|---|---|---|
| ***Home Assessment*** | | |
| Home Assessment Consent (Attachment C) | Form outlining what will be measured in the unit, the purpose of the measurements, how data will be used, and next steps. | To obtain informed consent from study participants to conduct pre- and post-intervention air quality and allergen measurements in the unit, record participant observations, and obtain responses to survey questions. |
| Direct Measurements (Attachment D) | Sampling of indoor and outdoor temperature, relative humidity, carbon dioxide, carbon monoxide, particulate matter, volatile organic compounds, and cockroach and mouse allergens. To be conducted pre- and post-intervention by field staff. | Obtain pre- and post-intervention measurements of air pollutant and allergen levels in the units of participants to assess intervention effects on indoor air pollutant and allergen levels. |
| Interviewer Observations (Attachment E) | Pre- and post-intervention checklist and questionnaire to be completed by field staff. | Report on observations within units that may impact direct field measurements and that complement self-reported survey information. |
| Survey (Attachments F.1 and F.2) | Self-completed pre- and post-intervention surveys with 24-25 questions. | Assess self-reported pre- and post-intervention information on potential sources of indoor pollution and allergens and on health conditions of children living in the unit that could be associated with exposure to air pollutants and/or allergens. |
| ***Child Assessment*** | | |
| Child Assessment & Obesity and Type II Diabetes Risk Assessment : Assent (Attachment G) | Form outlining what information will be collected in the Obesity and Type II Diabetes Risk Assessment & Child Assessment, how the information will be used, and next | To obtain assent from children ages 10+. The form to obtain full consent for The Obesity and Type II Diabetes Risk Assessment & Child Assessment from parents can be found in Attachment L. |

| | | |
|---|---|---|
| | steps. | |
| Survey about Child (questions asked of parent or guardian) (Attachments H.1 and H.2) | Interviewer-administered baseline and two-year follow-up surveys with parent or guardian reporting on child behavioral and mental health, physical health, number of schools attended, school absences, school engagement, and community activities outcomes for one child ages 2-15 at baseline and on their caregiving practices, housing quality, and home environment. | Obtain information from the parent or guardian about potential effects of intervention on child and caregiving outcomes and on the home environment as a potential moderator of intervention effects. |
| Direct Child Assessment (Attachments I.1, I.2, and I.3) | Includes a self-completed tablet-based assessment of child executive functioning of a single randomly selected child in each study household and a brief interviewer-administered survey for those children who are 8 or older on child behavioral and mental health and physical health outcomes. | Assess intervention effects on children's executive functioning and mental and physical health. |
| ***The Obesity and Type II Diabetes Risk Assessment*** | | |
| Obesity and Type II Diabetes Risk Assessment & Child Assessment Consent (Attachment L) | Form outlining what information will be collected in the adult survey, adult anthropometric assessments, blood spot sample, accelerometer, child anthropometric assessment, blood pressure monitoring and child accelerometer. The form will also detail how the information will be used, and next steps. | To obtain informed consent from adults to participate in the research study, and for the child of whom they are the parent or guardian to participate. Children ages 10+ will also provide their written assent (please see Attachment G for assent). |
| Adult Survey (Attachments M.1 and M.2) | Interviewer-administered 70-minute survey that includes domains related to diet and exercise, sleep habits, mental health, perceived neighborhood and food environment, social support, discrimination, healthcare access, and use of social services. | To understand how moving to an opportunity neighborhood has the potential to impact adult health outcomes, like obesity and type II diabetes, and the pathways through which these changes are likely to occur. By administering this survey at both baseline (before moving) and follow-up (after moving) to a group being offered CMRS and a control group, researchers will be able to determine whether these factors change between study groups over the 2-year period. |
| Anthropometric assessments (adult) (Attachment N) | At each home visit, trained research staff will measure height and weight of the adult using a portable stadiometer and digital scale along | To assess whether adults in families offered CMRS (intervention group) exhibit changes in obesity risk after 2 years compared to the control group that |

| | | |
|---|---|---|
| | with waist circumference. BMI (weight in kg divided by height in $m^2$) will be calculated. | receives no special mobility services. Height and weight will be used to calculate BMI,[8] one of the primary outcome measures for adults in this research study, and waist circumference will be used to assess abdominal obesity. |
| Anthropometric assessments (child) (Attachment O) | At each home visit, trained research staff will measure height and weight of the enrolled child aged 2-15 using a portable stadiometer and digital scale along with waist circumference. Age- and sex-standardized BMI z-scores for children will be calculated. | To assess whether children in families offered CMRS exhibit changes in obesity risk after 2 years compared to the control group that receives no special mobility services. Height and weight will be used to calculate BMI z-score, the primary outcome measure for children in this research study and waist circumference will be used to measure abdominal obesity. |
| Blood spot samples (adult) (Attachment P) | At each home visit, trained research staff will collect capillary blood from adults to measure HbA1c using a mail-in testing kit for the adult. | To assess whether adults in families offered CMRS (intervention group) exhibit changes in type II diabetes risk (HbA1c levels) after 2 years compared to the control group that receives no special mobility services. |
| Home Observations/Housing Assessment (Attachment Q) | Pre- and post-intervention checklist and questionnaire to be completed by field staff. | Report on observations within units and neighborhood that complement self-reported survey information. |
| Accelerometers(adult) (Attachment R) | At the baseline home visit, a random subset of adult participants from each study group (approximately half from the group offered CMRS and the other half from the control group) will be offered the opportunity to wear the accelerometer at baseline and at 2-year follow-up. At the two time points, the accelerometer will be fastened to the participant's non-dominant wrist with an adjustable band to be worn for 7 consecutive days. | To understand how physical activity and sleep may change for adults between groups when moving to an opportunity area. |
| Accelerometers (child) (Attachment S) | At the baseline home visit, a random subset of child participants aged 2-15 from each study group | To understand how physical activity and sleep may change for children between groups when moving to an opportunity |

[8] This study is using BMI to monitor average changes in body weight independent of height in a population over time. BMI is a valid measure for this purpose across racial/ethnic groups (that is, weight scales similarly with height in Non-Hispanic white, Non-Hispanic Black, and Mexican men and women when controlling for adiposity and age). However, this study is not communicating health risks with individual participants based on BMI. This is because it can be problematic when BMI is used out of context to communicate health risks with individuals due to differences in the relationship between fat mass and BMI across racial/ethnic groups.

| | | |
|---|---|---|
| | (approximately half from the group offered CMRS and the other half from the control group) will be offered the opportunity to wear the accelerometer at baseline and 2-year follow-up. At the two time points, the accelerometer will be fastened to the participant's non-dominant wrist with an adjustable band to be worn for 7 consecutive days. | area. |
| Blood pressure reading (adults) (Attachment T) | Blood pressure will be measured using an electronic blood pressure monitor at baseline and 2-year follow-up. | Obtain direct measure of blood pressure which is strongly associated with obesity and type II diabetes risk and hypothesized to be related to neighborhood change. |
| Consent for semi-structured interviews (Attachment U) | Form outlining what information will be collected in the in-depth interview, how the information will be used, and next steps. | To obtain informed consent from adults to participate in the 90-minute in-depth interview. |
| Semi-structured interviews (Attachment V) | Interviewer administered 90-minute semi-structured in-depth interview with a subset of adults from each study group (group offered CMRS and control group). Interview questions will dive deeper into concepts explored in the initial questionnaire, such as the perceived barriers and facilitators to eating healthful foods, the role of mental health and social support in influencing behavioral factors. | To elicit perceived mechanisms through which randomization to CRMS relative to the control group impacts health and well-being. |
| Tracking Email/Text (Attachment W) | Online portal with unique login where the adult can update or confirm their name, address, phone, and email information as well as contact information for someone who will always know how to reach them. Self-administration expected to take 8 minutes. | To obtain updated contact information in order to maximize the response rates for the follow-up data collection efforts |
| Tracking Call (Attachment X) | Interviewer administered 10-minute call where interviewers will ask the adult to update or confirm their name, address, phone, and email information as well as contact information for someone who will always know how to reach them. | To obtain updated contact information in order to maximize the response rates for the follow-up data collection efforts |

The estimates of the number of respondents in Exhibit A-4 are based on the three-year duration of this Information Collection Request. Data collection related to the Demonstration in

subsequent years will be addressed in a subsequent filing to renew the initial information collection authorization.

**3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.**

For the Child Assessment and the Obesity and Type II Diabetes Risk Assessment, the evaluation contractor will use automated technology to enhance the collection of information under the Demonstration and reduce burden.

- They will program CAPI (computer-assisted personal interview) instruments using Confirmit, the evaluator's data collection platform, and interviewers will administer the surveys in-person using their tablets. The CAPI instruments will allow the evaluator to include automatic skip patterns that will route participants to only questions that are relevant to them based on their previous answers. The evaluator will also include programmed data validations to prevent outliers and inconsistent answers as well as scripted probes for interviewers so that they can follow-up on inconsistent or unclear responses.
- The evaluator will also use tablets for self-administered portions of the data collection. For example, they will administer the tablet-based Minnesota Executive Functioning Scale assessment to children to streamline data collection.
- The evaluation contractor will implement a multi-pronged and technologically enhanced strategy to track and retain enrolled participants across the study period and to field the data collection. To encourage participant tracking and engagement, the team will establish a project website. The website will serve as an electronic "home" for the study. Participants will be able to go to a stable URL at any time to log on and update their contact information. The website will also include updates on study activities and a set of Frequently Asked Questions (FAQs), both of which will help keep participants engaged with the study. Between enrollment and follow-up, the evaluation contractor will also reach out to participants to remain engaged in the study using phone calls, SMS texts, and emails, so that they can strengthen their rapport with participants and update their contact information. This will help to ensure that interviewers can easily reach participants in their preferred and most convenient communication mode for follow-up data collection.
- Consistent with enrollment into the main study, the evaluation contractor will obtain informed consent electronically, subject to state and local laws and IRB requirements. Having electronic consent reduces the paperwork requirements of the study, reduces the staff labor necessary to track the receipt status of paper consent forms and streamlines the informed consent process with participants.

The Home Assessment will capture data using a web-based survey. Field staff will provide respondents with computer tablets on which to complete the surveys, thus reducing paperwork and the burden on participants. The Home Assessment will also utilize the environmental sampling equipment as outlined in Exhibit A.2.

**Exhibit A.2: Environmental Sampling Equipment**

| Environmental Sample | Sampling Protocol |
|---|---|
| Temperature (°F and °C) | TSI Indoor Air Quality Meter 7575 (or compatible) |
| Relative humidity (%) | TSI Indoor Air Quality Meter 7575 (or compatible) |
| Carbon dioxide ($CO_2$) concentration | TSI Indoor Air Quality Meter 7575 (or compatible) |
| Carbon monoxide (CO) concentration | TSI Indoor Air Quality Meter 7575 (or compatible) |
| Mouse (Mus m 1) and cockroach (Bal g1) allergens | Low flow air sampling pumps (BDX-11 or comparable) |
| Dust (particulate matter - $PM_{10}$, $PM_{2.5}$) | TSI P-Trak Particle Counter 8525 (or compatible) |
| Volatile organic compounds (VOCs) | Rae Systems MultiRae Lite PID Monitor (059-A or compatible) |

**4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2.**

The information collected through these three assessments cannot be collected through other data sources. The direct assessment must be conducted using trained data collectors to ensure consistency and accuracy. The evaluation contractor will ensure that the additional data collected under this information collection request does not duplicate the data collected from families previously. The evaluation contractor will have access to the data that families provided through the previously approved Baseline Information Form and Survey as part of their enrollment into the main Demonstration. The evaluation contractor will also draw upon HUD and PHA administrative data to reduce the burden of direct data collection from the study participants and to avoid duplication of effort by collecting data available elsewhere.

**5. If the collection of information impacts small businesses or other small entities (Item 5 of OMB Form 83-I) describe any methods used to minimize burden.**

There are no small business respondents or other small entities in this phase of the data collection.

**6. Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.**

The Consolidated Appropriations Act, 2019 (Pub. L. 116-6) and the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) authorized and required the U.S. Department of

Housing and Urban Development (HUD) to implement and evaluate the Housing Choice Voucher (HCV) Mobility Demonstration (now known as the Community Choice Demonstration. The data to be collected through this information collection request will contribute to this congressionally mandated evaluation. Specifically, these data will help HUD determine what the short-term outcomes are for health, mental health, and other outcomes for adults and children in families who make opportunity moves relative to those who do not.

The burden has been reduced to the minimum necessary to achieve the purposes of the Demonstration. No technical or legal obstacles to reducing burden have been identified beyond the need to protect privacy and ensure that interviewees engage in informed consent.

**7. Explain any special circumstances that would cause an information collection to be conducted in a manner:**

- requiring respondents to report information to the agency more than quarterly;
    - This circumstance is not applicable.
- requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
    - This circumstance is not applicable.
- requiring respondents to submit more than an original and two copies of any document;
    - This circumstance is not applicable.
- requiring respondents to retain records other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
    - This circumstance is not applicable.
- in connection with a statistical survey, that is not designed to produce valid and reliable results than can be generalized to the universe of study;
    - This circumstance is not applicable.
- requiring the use of a statistical data classification that has not been reviewed and approved by OMB;
    - This circumstance is not applicable.
- that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
    - This circumstance is not applicable.

- requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.
    - This circumstance is not applicable.

The proposed data collection activities are consistent with the guidelines set forth in 5 CFR 1320 (Controlling Paperwork Burdens on the Public). There are no special circumstances that require deviation from these guidelines. Thus, each of the requirements above are **"Not Applicable"** to this collection.

**8. If applicable, provide a copy and identify the date and page number of publications in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.**

- Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping disclosure, or reporting format (if any) and the data elements to be recorded, disclosed, or reported.
- Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that preclude consultation in a specific situation. These circumstances should be explained.

The notice, soliciting comments on the information collection, was posted in the Federal Register on 06/22/2023, Volume 88, Number 119, pages 40841-40844, and provided a sixty-day period for public comment. During the notice and comment period, no public comments were received. Please see the link to the Federal Register notice below.

2023-13223.pdf (govinfo.gov)

**9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.**

Each of the assessments and/or their components have incentives that are provided to acknowledge the significant time that respondents spend participating. Exhibit A.3 shows the planned incentive amount for each respondent type.

**Exhibit A.3: Planned Respondent Incentives**

| Information Collection | Incentive Amount | Incentive Type |
|---|---|---|
| Home Assessment | $45 (baseline), $50 (follow-up) | Gift Card |
| Child Assessment | $30 (baseline), $35 (follow-up) | Gift Card |

| | | |
|---|---|---|
| Obesity and Type II Diabetes Risk Assessment Anthropometric assessments and survey (adult) | $60 (baseline), $70 (follow-up) | Gift Card |
| Obesity and Type II Diabetes Risk Assessment Anthropometric assessments (child) | $10 (baseline), $10 (follow-up) | Gift Card |
| Obesity and Type II Diabetes Risk Assessment Blood spot samples | $25 (baseline), $25 (follow-up) | Gift Card |
| Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment (adult) | $25 (baseline), $25 (follow-up) | Gift Card |
| Accelerometers for subset of Obesity and Type II Diabetes Risk Assessment (child) | $25 (baseline), $25 (follow-up) | Gift Card |
| The Obesity and Type II Diabetes Risk Assessment: Blood pressure readings | $15 (baseline), $15 (follow-up) | Gift card |
| Semi-structured interviews for subset of Obesity and Type II Diabetes Risk Assessment | $75 | Gift Card |

A major justification for the use of incentives is the length of each assessment. Assessments that take about 60 minutes or more to complete could interfere in family commitments or result in unforeseen other expenses associated with research participation. Without offsetting the direct costs incurred by respondents for attending (which may include time off from paid work), the evaluation contractor increases the risk that only those individuals able to overcome the financial barriers to attend will participate in the study, thus limiting the experiences the evaluation is able to capture. Further, leading survey research organizations, American Association for Public Opinion Research (AAPOR) and American Statistical Association (ASA), agree that incentives improve response rates and are financially prudent for researchers, because they reduce time spent pursuing responses and improve the ability to interview families of interest.[9]

To avoid coercion, the consent statements for each interview guide will accurately state known benefits and risks of participation without exaggerating them. Individuals with disabilities will be provided reasonable accommodations and evaluation contractors will ensure effective communication with individuals with disabilities during this study. Similarly, meaningful access will be provided to speakers with limited English proficiency.

[9] Berlin, Martha, Leyla Mohadjer, Joseph Waksberg, Andrew Kolstad, Irwin Kirsch, D. Rock, & Kentaro Yamamoto. 1992. "An experiment in monetary incentives." Proceedings of the Survey Research Methods Section of the American Statistical Association. Alexandria, VA: American Statistical Association.

**10. Describe any assurance of confidentiality provided to respondents and the basis for assurance in statute, regulation, or agency policy.**

Because of the nature of the information collected from and about study participants, strict confidentiality procedures will be followed for this evaluation. The information requested under this collection is protected and held confidential in accordance with 5 U.S.C. § 552a (Privacy Act of 1974) and OMB Circular No. A-130. Federal disability law provides further protection to ensure the confidentiality of information that respondents disclose about any disability. Study participants will be assured they need not disclose any medical or disability related information if they do not wish to, but if they do disclose that information it will not be shared in a personally identifiable way with anyone other than study team and HUD's Office of Policy Development & Research or used in any way to impact their eligibility for any public program or activity.

As required by 5 U.S.C. 552a (Privacy Act of 1974), HUD has published a Systems of Record Notice (SORN) in the Federal Register for the main study on May 27, 2022, and it was effective as of June 27, 2022. Please see link to the notice below.

https://www.federalregister.gov/documents/2022/05/27/2022-11452/privacy-act-of-1974-system-of-records

Prior to beginning the data collections included in this submission, the study protocols and materials will be reviewed in detail by Abt Associates' Institutional Review Board (IRB) and Abt Associates' Cybersecurity team.

**Informed Consent**

The study has been designed to allow all potential participants to make a genuinely informed decision about participation. Vigorous outreach with a clear message and strong supporting materials will be used to ensure that families enrolled in the study understand the entirety of each assessment if applicable.

The Home Assessment will have its own consent form. The consent forms for the Child Assessment and the Obesity and Type II Diabetes Risk Assessment will be combined into a single consent form; respondents will have the ability to decide which elements of the study they wish to participate in and have the child participate in. The consent form will be written in plain language so that participants can understand it. Options for those who need reasonable accommodations for individuals with disabilities will be provided for families interested in participating. Language assistance options will also be provided for persons with limited English proficiency to be able to enroll in the study and provide informed consent.

As with all the Assessments, participants in the Obesity and Type II Diabetes Risk Assessment will have the option of participating in some or all of the data collection activities.

**Data Confidentiality Protections**

The evaluation contractor shall protect respondent privacy to the extent permitted by law and will comply with all Federal and Departmental regulations for private information. The evaluation contractor will develop a Data Security Plan that assesses all protections of

respondents' PII. The evaluation contractor shall ensure that all employees, subcontractors (at all tiers), and employees of each subcontractor, who perform work under this contract/subcontract, are trained on data privacy issues and comply with the above requirements.

The evaluation contractor shall use Federal Information Processing Standard compliant encryption (Security Requirements for Cryptographic Module, as amended) to protect all instances of sensitive information during storage and transmission. The evaluation contractor shall securely generate and manage encryption keys to prevent unauthorized decryption of information, in accordance with the Federal Processing Standard. The evaluation contractor shall: ensure that this standard is incorporated into the evaluation contractor's property management/control system; establish a procedure to account for all laptop computers, desktop computers, and other mobile devices and portable media that store or process sensitive information. Any data stored electronically will be secured in accordance with the most current National Institute of Standards and Technology (NIST) requirements and other applicable Federal and Departmental regulations. In addition, the evaluation contractor will submit a plan for minimizing to the extent possible the inclusion of sensitive information on paper records and for the protection of any paper records, field notes, or other documents that contain sensitive or PII that ensures secure storage and limits on access.

All data collected and maintained by the evaluation contractor will be stored securely in the cloud-based system. Data extracted from those tools and all other data collected for this study will reside within the secure ACE 3 Data Collection Platform maintained by evaluation contractor Abt Associates. Only staff with a need to use the data will have access to the data.

An assurance of confidentiality to the extent provided by law is included in the study consent agreement through which participants provide informed consent. An assurance of confidentiality to the extent provided by law will also be made to all respondents as part of the introduction to each of the data collection activities.

**11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.**

The instruments included in this information collection request contain some questions that may be deemed sensitive in nature by some study participants, such as weight control behaviors and perceptions of body image, physical health, mental health, police involvement, substance use, experiences of discrimination and bullying, food security status, and participation in social services programs. This information is important to the study to understand potential pathways through which moving to an opportunity neighborhood may affect health and mental health outcomes, such as obesity and type II diabetes risk.

All respondents will be informed that their participation is voluntary, that they can choose not to answer any question, and that their responses will be kept confidential to the fullest extent possible under the law. The limited circumstances that would require a breach of confidentiality are outlined by the Institutional Review Board and pertain to such matters as abuse. Prior to any questions being asked, the interviewer will obtain informed consent/assent from all participants. Surveys will be administered in the comfort of the participant's home with a trained interviewer. Interviewers will be trained on sensitive questions and will remind participants that they can refuse to respond to any question they are not comfortable answering. Prior to the family interviews, interviewers will ask that respondents find a quiet place where they can talk freely, without distraction and to ensure no one else can listen in.

**12. Provide estimates of the hour burden of the collection of information. The statement should:**

- indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices;
- if this request covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13 of OMB Form 83-I; and
- provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories.
- The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 13.

**Estimated Number of Respondents:** The baseline and follow-up assessments for the Home, Child, and the Obesity and Type II Diabetes Risk Assessments will be completed for an estimated 2,370 respondents. This consists of 570 heads of household participating in the Home Assessment and 900 parents or guardians and 900 children participating in the Obesity and Type II Diabetes Risk Assessment. We estimate that the Child Assessment will be administered to 837 families that also participate in the Obesity and Type II Diabetes Risk Assessment, so they are already included in the estimated number of respondents above.

**Frequency of Response:** For most of the instruments the frequency of response is two: baseline and follow-up. The only data collection item that will be used once is the semi-structured interview for the Obesity and Type II Diabetes Risk Assessment, which will only be conducted with a sample of 75 adults at follow-up.

**Annual Burden:** The estimated total annual burden of this information collection is 280,466.73 hours. The estimated total annual cost for this information collection is $**1,592,012.29**. The estimated total annual cost is calculated by multiplying the total number of respondent hours for adults by $11.05. The hourly rate of $11.05 was calculated using the average hourly minimum wage rate for families in the Housing Choice voucher program living in the 8 study sites.[10] Annualized cost estimates were not calculated for the child sample. The child sample eligible to participate in the study will be under the age of 18. Most, if not all, will be enrolled in school and working part-time at the most. Thus, we did not calculate an hourly wage for the child sample. Below is a breakdown of each assessment's data collection components.

*Home Assessment*

The Home Assessment includes an advance letter (5 minutes or .08 hours), an email (1 minute or .02 hours), and a follow-up call from the research team (8 minutes or .13 hours). It also includes the consent (10 minutes or .17 hours), direct measurement (30 minute or .5 hours), interviewer observations (10 minutes or .17 hours) and a brief survey (15 minutes or .25 hours), representing a total respondent burden of 1.32 hours. The burden table reflects the evaluation contractor's estimate that it may need to conduct initial outreach, via emails, letters, and phone calls, to up to 814 families in order to recruit 570 families to participate in the Home Assessment.

*Child Assessment*

The Child Assessment includes the consent (8 minutes or .13 hours), a survey about the child (asked of parent/guardian) and parent/guardian's presence during direct child assessment (a total of 45 minutes or .75 hours), and a direct child assessment (32 minutes or .53 hours per child). This represents a total respondent burden of 85 minutes or 1.42 hours. Consent for the Child Assessment and the Obesity and Type II Diabetes Risk Assessment will be obtained at the same time, through the same instrument; we have apportioned the total time estimate for the combined instrument across the two assessments.

[10] Hourly minimum wage rates were averaged across the eight study sites, which include Los Angeles, Louisiana, Minnesota, New York City, New York State, Ohio, Pennsylvania, and Tennessee.

| Annualized Burden Table | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Information Collection** | **Number of Respondents** | **Frequency of Response** | **Responses Per Annum** | **Burden Hour Per Response** | **Annual Burden Hours** | **Hourly Cost Per Response** | **Annual Cost** |
| ***Home Assessment*** | | | | | | | |
| Advance Letter | 814 | 2 | 1,628 | 0.08 | 130.24 | $11.05 | $1,439.15 |
| Email Reminder | 814 | 2 | 1,628 | 0.02 | 32.56 | $11.05 | $359.79 |
| Follow-up Call Phone Script | 814 | 2 | 1,628 | 0.13 | 211.64 | $11.05 | $2,338.62 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Consent for Assessment | 570 | 2 | 1,140 | 0.17 | 193.80 | $11.05 | $2,141.49 |
| Direct Measurements | 570 | 2 | 1,140 | 0.50 | 570.00 | $11.05 | $6,298.50 |
| Interviewer Observations | 570 | 2 | 1,140 | 0.17 | 193.80 | $11.05 | $2,141.49 |
| Survey | 570 | 2 | 1,140 | 0.25 | 285.00 | $11.05 | $3,149.25 |
| ***Child Assessment*** | | | | | | | |
| Consent for Assessment | 837 | 2 | 1,674 | 0.13 | 217.62 | $11.05 | $2,404.70 |
| Survey about child (asked of parent/guardian) and parent/guardian's presence during direct Child Assessment | 837 | 2 | 1,674 | 0.75 | 1,255.50 | $11.05 | $13,873.28 |
| Direct Child Assessment | 837 | 2 | 1,674 | 0.53 | 887.22 | N/A | N/A |
| ***The Obesity and Type II Diabetes Risk Assessment*** | | | | | | | |
| Advance Letter | 1,285 | 2 | 2,570 | 0.08 | 205.60 | $11.05 | $2,271.88 |
| Email Reminder | 1,285 | 2 | 2,570 | 0.02 | 51.40 | $11.05 | $567.97 |
| Follow-up Call Phone Script | 1,285 | 2 | 2,570 | 0.13 | 334.10 | $11.05 | $3,691.81 |
| Consent for Assessment | 900 | 2 | 1,800 | 0.25 | 450.00 | $11.05 | $4,972.50 |
| Adult Survey | 900 | 2 | 1,800 | 1.17 | 2,106.00 | $11.05 | $23,271.30 |
| Anthropometric assessments (adult) | 900 | 2 | 1,800 | 0.17 | 306.00 | $11.05 | $3,381.30 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anthropometric assessments (child) | 900 | 2 | 1,800 | 0.17 | 306.00 | N/A | N/A |
| Anthropometric assessments (child, but accounting for parent's time) | 900 | 2 | 1,800 | 0.17 | 306.00 | $11.05 | $3,381.30 |
| Blood Spot Samples (adult) | 900 | 2 | 1,800 | 0.17 | 306.00 | $11.05 | $3,381.30 |
| Home Observations/ Housing Assessment | 900 | 2 | 1,800 | 0.25 | 450.00 | $11.05 | $4,972.50 |
| Accelerometers (adult) | 400 | 2 | 800 | 169.00 | 135,200.00 | $11.05 | $1,493,960.00 |
| Accelerometers (child) | 400 | 2 | 800 | 169.00 | 135,200.00 | N/A | N/A |
| Blood Pressure Reading (adult) | 900 | 2 | 1,800 | 0.25 | 450.00 | $11.05 | $4,972.50 |
| Consent for Semi-Structured Interviews | 75 | 1 | 75 | 0.17 | 12.75 | $11.05 | $140.89 |
| Semi-Structured Interviews | 75 | 1 | 75 | 1.50 | 112.50 | $11.05 | $1,243.13 |
| Tracking Emails/Texts | 900 | 2 | 1,800 | 0.13 | 234.00 | $11.05 | $2,585.70 |
| Tracking Calls | 900 | 3 | 2,700 | 0.17 | 459.00 | $11.05 | $5,071.95 |
| **Totals** | **2,936** | | **42,826** | | **280,466.73** | | **$1,592,012.29** |

*Obesity and Type II Diabetes Risk Assessment*

The Obesity and Type II Diabetes Risk Assessment includes an advance letter (5 minutes or .08 hours), an email (1 minute or .02 hours), and a follow-up call from the research team (8 minutes or .13 hours). It also includes consent and enrollment (15 minutes or .25 hours); adult survey (70 minutes or 1.17 hour); anthropometric assessments for adults (10 minutes or 0.17 hours) and children (10 minutes or 0.17 hours and 10 minutes or .17 hours for the parent or guardian who must also be present); and blood spot sample of the adult (10 minutes or 0.17 hours). The home observations/housing assessment will take 15 minutes (.25 hours). The accelerometer is expected to take adults and children one hour to put on and return. Returning the accelerometer will involve the participant placing the device in the self-addressed, postpaid return envelope that the interviewer provided and mailing it back to the study team. We also included the full burden of participants wearing the accelerometer for 7 days for a total burden of 169 hours. We expect the blood pressure reading to take 15 minutes or .25 hours. Finally, for the subset of 75 adults that are interviewed as part of the semi-structured interviews, consent is expected to take 10 minutes

(or .17 hours) and the interviews are expected to take 60-90 minutes, or 1-1.5 hours. The Tracking emails/texts, to be administered twice during the follow-up period, are expected to take 8 minutes (.13 hours) and the tracking calls, to be administered three times during the follow-up period, are expected to take 10 minutes (.17 hours) to complete. The burden table reflects the evaluation contractor's estimate that it may need to conduct initial outreach, via emails, letters, and phone calls, to up to 1,285 families in order to recruit 900 families to participate in the Obesity and Type II Diabetes Risk Assessment.

**Exhibit A.4: Annualized Burden Table**

**13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information (do not include the cost of any hour burden shown in Items 12 and 14).**

- **The cost estimate should be split into two components: (a) a total capital and start-up cost component (annualized over its expected useful life); and (b) a total operation and maintenance purchase of services component. The estimates should take into account costs associated with generating, maintaining, and disclosing or providing the information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s) and the time period over which costs will be incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities;**
- **If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting our information collection services should be a part of this cost burden estimate. In developing cost burden estimates, agencies may consult with a sample of respondents (fewer than 10) utilize the 60-day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.**
- **Generally, estimates should not include purchases of equipment or services, or portions thereof made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.**

This data collection effort involves no recordkeeping or reporting costs for respondents other than the time burden to respond to questions on the data collection instruments as described in item A.12. There is no known cost burden to the respondents.

**14. Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.**

The data collection for the Home and Child Assessments will be carried out under a HUD Contract with Abt Associates. The data collection for the Obesity and Type II Diabetes Risk Assessment is funded by a grant to Johns Hopkins University from the National Institute of Diabetes and Digestive and Kidney Diseases as part of the MOVED study. Data collection for this effort will be carried out under a contract between Johns Hopkins University and Abt Associates. HUD estimates the total cost to the Federal government of the data collection effort over the three-year term of this information collection to be approximately $6,400,000 (see Exhibit A.5).

The professional labor includes the labor hours required to implement three assessments, including the administration of informed consent to all study participants: 1) the Home Assessment Survey; 2) the Child Assessment; and 3) the Obesity and Type II Diabetes Risk Assessment. The labor hours also include time to process the responses to these three survey efforts. This includes the cost related to salaries of Abt Associates employees, hours for subcontracted interviewers, and operational expenses such as developing the web-based data collection system, translation costs, and mailing and shipping costs.

The total incentive fees anticipated to be paid are based on the expected response rate and the incentive to be offered for each outreach effort.

**Exhibit A.5: Estimated Annual Cost to the Federal Government**

| Activity | Estimated Cost to Federal Government |
|---|---|
| Home Assessment | $1,000,000 |
| Child Assessment | $900,000 |
| Obesity and Type II Diabetes Risk Assessment, first three years | $4,500,000 |
| **Total costs over the request period** | **$6,400,000** |
| **Annual costs per year** | **$2,133,333** |

**15. Explain the reasons for any program changes or adjustments reported in Items 13 and 14 of the OMB Form 83-I.**

Under OMB Control #2528-0337, OMB approved the information collection to support the enrollment of families into the Demonstration, along with instruments to support a series of qualitative interviews with key stakeholders in the Demonstration, and cost data collection

components, in May and June 2022. Approval for those previously approved instruments is valid through June 2025.

This information collection request includes three new components to expand the Community Choice Demonstration research: a Home Assessment, a Child Assessment, and an Obesity and Type II Diabetes Risk Assessment. These assessments—and the various data collection components associated with them—will focus on understanding the effects of being offered mobility-related services on the physical and mental health and health behavior of a subset of adults and children participating in the Demonstration. The Obesity and Type II Diabetes Risk Assessment is funded by the National Institute of Diabetes and Digestive and Kidney Diseases and led by Johns Hopkins University as part of a study called the MOVED study. These new data collection components and the associated burden have been calculated, as shown in Exhibit A.4 above.

The evaluation contractor will also complete data collection with previously approved instruments. This request does not include any changes to the content of those instruments or to the estimated time to complete.

**16. For collection of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.**

The planned impact analyses rely on data collected under this information collection request. This section first provides an overview of the data collection schedule, with the projected timing of each activity. The section then shows the timing for the publication plans that will be conducted in support of the Demonstration evaluation. The details on the analysis plans and report content are described in Supporting Statement B.

Exhibit A.6 shows the timing for the data to be collected under this information collection request and related reports.

**Exhibit A.6*:* Data Collection and Report Schedule**

| Milestone | Timing |
|---|---|
| Begin Data Collection (Home Assessment, Child Assessment, and Obesity and Type II Diabetes Risk Assessment) | January 2024 |
| End Data Collection for Home Assessment | January 2026 |
| Final Report for Home Assessment | June 2026 |
| End Data Collection for Child and Obesity and Type II Diabetes Risk Assessments | June 2027[11] |
| Final Report for Child Assessment | September 2027 |

[11] Since the projected ending date for data collection extends beyond the three-year period covered by this information collection, we will request an amendment to accommodate the additional data collection.

| Milestone | Timing |
|---|---|
| Peer-reviewed articles based on the Obesity and Type II Diabetes Risk Assessment | TBD |

*Home Assessment*

The Home Assessment Report will provide a summary of analyses estimating the impact of being offered CMRS on indoor air pollutants and allergens, as well as on self-reported health conditions related to indoor air quality. The Home Assessment impact analysis will be conducted using methods similar to those used for the Phase 1 Impact Evaluation Report for the Demonstration. Additionally, in order to guard against potential bias, the Home Assessment impact analysis will test for possible non-equivalence in baseline values for indoor air pollutants and allergens. If we find non-equivalence at baseline, we will develop and use a set of analysis weights so that the two study groups have equivalent average baseline values. The report will also summarize descriptive findings from: 1) comparisons of study participants with residences in opportunity areas versus study participants with residences in non-opportunity areas; and 2) comparisons of study participants who moved versus study participants who did not move (regardless of whether the destination is an opportunity area). The report will briefly summarize prior research on the relationships between mobility, indoor air quality, and respiratory health.

The report will provide an overview of the study's research questions, include sections that present findings addressing each of the research questions, and conclude with a summary of these findings. A technical appendix will include a brief summary of the analysis methods and additional exhibits that provide more detailed results for the analyses conducted.

*Child Assessment*

The Child Assessment Report will provide a summary of impact analyses conducted on the effects of CMRS on children's mental health, behavior, physical health, social functioning, executive functioning, and educational outcomes, as well as on parenting practices.

Impact analyses will be conducted using largely similar methods as those used for the Phase 1 Impact Evaluation Report for the Demonstration. Child Assessment impact analyses will additionally include analysis weights to account for (1) the probability of selection as a focal child within the household, (2) non-response at follow-up, and (3) any baseline characteristics on which the sample that enrolls into the Child Assessment study is non-equivalent. The report will also summarize any differences in effects by children's age and gender identified. The report will briefly summarize prior research on the relationship between mobility and child outcomes, provide an overview of the research questions, include sections answering each of the research questions, and conclude with an integrative summary, including how findings from the child assessment may relate to findings from other planned Demonstration reports. A technical appendix will include a brief summary of the analysis methods and detailed impact analysis tables for analyses conducted.

*Obesity and Type II Diabetes Risk Assessment*

In one or more peer-reviewed articles, Johns Hopkins researchers will analyze the impacts of being offered CMRS on BMI and HbA1c (adults) and BMI z-score (children). The articles will also examine behavioral, psychosocial, contextual, and structural factors along the causal pathway. The primary analytic approach will use an intention-to-treat framework and, in secondary analyses, will account for intervention take-up. In addition, the articles will analyze in-depth interview data from approximately 75 adults to examine mechanisms through which moving to a more affluent neighborhood impacts obesity and type II diabetes risk.

**17. If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.**

All data collection instruments will prominently display the expiration date for OMB approval.

**18. Explain each exception to the topics of the certification statement identified in "Certification for Paperwork Reduction Act Submissions."**

This submission describing data collection requests no exceptions to the Certification for Paperwork Reduction Act Submissions (5 CRF 1320.9).