mulative total of more than 2,000 cases of acquired immune deficiency syndrome for the most recent period of 5 calendar years for which such data are available.'' for ''metropolitan area for which, as of June 30, 1990, in the case of grants for fiscal year 1991, and as of March 31 of the most recent fiscal year for which such data is available in the case of a grant for any subsequent fiscal year—

''(1) there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of more than 2,000 cases of acquired immune deficiency syndrome; or

''(2) the per capita incidence of cumulative cases of such syndrome (computed on the basis of the most recently available data on the population of the area) is not less than 0.0025.''

Pub. L. 104–146, §3(a)(1)(A), substituted ''subject to subsections (b) through (d)'' for ''subject to subsection (b)''.

Subsecs. (c), (d). Pub. L. 104–146, §3(a)(2), added subsecs. (c) and (d).

1992—Subsecs. (a)(1), (b). Pub. L. 102–531 substituted ''Centers for Disease Control and Prevention'' for ''Centers for Disease Control''.

EFFECTIVE DATE OF 2009 AMENDMENT; REVIVAL OF SECTION

Pub. L. 111–87, §2(a)(2), (3), Oct. 30, 2009, 123 Stat. 2885, provided that:

''(2) EFFECTIVE DATE.—Paragraph (1) [repealing section 703 of Pub. L. 109–415, formerly set out as an Effective Date of Repeal note below] shall take effect as if enacted on September 30, 2009.

''(3) CONTINGENCY PROVISIONS.—Notwithstanding section 703 of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109–415; 120 Stat. 2767 [2820]) [repealing this subchapter, formerly set out as an Effective Date of Repeal note below] and section 139 of the Continuing Appropriations Resolution, 2010 [123 Stat. 2048]—

''(A) the provisions of title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.), as in effect on September 30, 2009, are hereby revived; and

''(B) the amendments made by this Act to title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) [see Tables for classification] shall apply to such title as so revived and shall take effect as if enacted on September 30, 2009.''

EFFECTIVE DATE OF REPEAL

Pub. L. 109–415, title VII, §703, Dec. 19, 2006, 120 Stat. 2820, which provided for the repeal of this subchapter effective Oct. 1, 2009, was itself repealed by Pub. L. 111–87, §2(a)(1), Oct. 30, 2009, 123 Stat. 2885.

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–146, §13, May 20, 1996, 110 Stat. 1374, provided that:

''(a) IN GENERAL.—Except as provided in subsection (b), this Act [enacting sections 300ff–27a, 300ff–31, 300ff–33 to 300ff–37, 300ff–77, 300ff–78, and 300ff–101 of this title, amending this section and sections 294n, 300d, 300ff–12 to 300ff–17, 300ff–21 to 300ff–23, 300ff–26 to 300ff–29, 300ff–47 to 300ff–49, 300ff–51, 300ff–52, 300ff–54, 300ff–55, 300ff–64, 300ff–71, 300ff–74, 300ff–76, and 300ff–84 of this title, transferring section 294n of this title to section 300ff–111 of this title, repealing sections 300ff–18 and 300ff–30 of this title, and enacting provisions set out as notes under sections 201, 300cc, and 300ff–33 of this title and section 4103 of Title 5, Government Organization and Employees], and the amendments made by this Act, shall become effective on October 1, 1996.

''(b) EXCEPTION.—The amendments made by sections 3(a), 5, 6, and 7 of this Act to sections 2601(c), 2601(d), 2603(a), 2618(b), 2626, 2677, and 2691 of the Public Health Service Act [42 U.S.C. 300ff–11(c), (d), 300ff–13(a), 300ff–28(b), 300ff–34, 300ff–77, 300ff–101] shall become effective on the date of enactment of this Act [May 20, 1996].''

STUDIES BY INSTITUTE OF MEDICINE

Pub. L. 106–345, title V, §501, Oct. 20, 2000, 114 Stat. 1352, required the Secretary of Health and Human Services to request the Institute of Medicine or another appropriate entity to conduct a study of State surveillance systems on the prevalence of HIV and a study concerning the relationship between epidemiological measures and health care for certain individuals with HIV and to ensure that the former study be completed and a report submitted to congressional committees not later than 3 years after Oct. 20, 2000, and that the latter study be completed and a report submitted to congressional committees not later than 2 years after Oct. 20, 2000.

STUDY REGARDING HIV DISEASE IN RURAL AREAS

Pub. L. 101–381, title IV, §403, Aug. 18, 1990, 104 Stat. 622 directed Secretary of Health and Human Services, after consultation with Director of the Office of Rural Health Policy, to conduct study for purpose of estimating incidence and prevalence in rural areas of cases of acquired immune deficiency syndrome and cases of infection with etiologic agent for such syndrome and determine adequacy in rural areas of services for diagnosing and providing treatment for such cases that are in early stages of infection, and provided that, not later than 1 year after Aug. 18, 1990, Secretary was to submit report to Congress.

§ 300ff–12. Administration and planning council

(a) Administration

(1) In general

Assistance made available under grants awarded under this subpart shall be directed to the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS, as reported to and confirmed by the Centers for Disease Control and Prevention, in the eligible area that is awarded such a grant.

(2) Requirements

(A) In general

To receive assistance under section 300ff–11(a) of this title, the chief elected official of the eligible area involved shall—

(i) establish, through intergovernmental agreements with the chief elected officials of the political subdivisions described in subparagraph (B), an administrative mechanism to allocate funds and services based on—

(I) the number of AIDS cases in such subdivisions;

(II) the severity of need for outpatient and ambulatory care services in such subdivisions; and

(III) the health and support services personnel needs of such subdivisions; and

(ii) establish an HIV health services planning council in accordance with subsection (b) of this section.

(B) Local political subdivision

The political subdivisions referred to in subparagraph (A) are those political subdivisions in the eligible area—

(i) that provide HIV-related health services; and

(ii) for which the number of cases reported for purposes of section 300ff–11(a) of this title constitutes not less than 10 percent of the number of such cases reported for the eligible area.

(b) HIV health services planning council

(1) Establishment

To be eligible for assistance under this subpart, the chief elected official described in subsection (a)(1) of this section shall establish or designate an HIV health services planning council that shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard that is in accordance with paragraph (5).

(2) Representation

The HIV health services planning council shall include representatives of—

(A) health care providers, including federally qualified health centers;

(B) community-based organizations serving affected populations and AIDS service organizations;

(C) social service providers, including providers of housing and homeless services;

(D) mental health and substance abuse providers;

(E) local public health agencies;

(F) hospital planning agencies or health care planning agencies;

(G) affected communities, including people with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations;

(H) nonelected community leaders;

(I) State government (including the State medicaid agency and the agency administering the program under part B of this subchapter);

(J) grantees under subpart II[1] of part C of this subchapter;

(K) grantees under section 300ff–71 of this title, or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area;

(L) grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services; and

(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV/AIDS as of the date on which the individuals were so released.

(3) Method of providing for council

(A) In general

In providing for a council for purposes of paragraph (1), a chief elected official receiving a grant under section 300ff–11(a) of this title may establish the council directly or designate an existing entity to serve as the council, subject to subparagraph (B).

(B) Consideration regarding designation of council

In making a determination of whether to establish or designate a council under subparagraph (A), a chief elected official receiving a grant under section 300ff–11(a) of this title shall give priority to the designation of an existing entity that has demonstrated experience in planning for the HIV health care service needs within the eligible area and in the implementation of such plans in addressing those needs. Any existing entity so designated shall be expanded to include a broad representation of the full range of entities that provide such services within the geographic area to be served.

(4) Duties

The planning council established or designated under paragraph (1) shall—

(A) determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status;

(B) determine the needs of such population, with particular attention to—

(i) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services;

(ii) disparities in access and services among affected subpopulations and historically underserved communities; and

(iii) individuals with HIV/AIDS who do not know their HIV status;

(C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—

(i) size and demographics of the population of individuals with HIV/AIDS (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));

(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;

(iii) priorities of the communities with HIV/AIDS for whom the services are intended;

(iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;

(v) availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the State Children's Health In-

[1] See References in Text note below.

surance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.] to cover health care costs of eligible individuals and families with HIV/AIDS; and

(vi) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;

(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 300ff–14 of this title that—

(i) includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);

(iii) is compatible with any State or local plan for the provision of services to individuals with HIV/AIDS; and

(iv) includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 300ff–14 of this title, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities;

(E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;

(F) participate in the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under part B of this subchapter;

(G) establish methods for obtaining input on community needs and priorities which may include public meetings (in accordance with paragraph (7)), conducting focus groups, and convening ad-hoc panels; and

(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.

(5) Conflicts of interest

(A) In general

The planning council under paragraph (1) may not be directly involved in the administration of a grant under section 300ff–11(a) of this title. With respect to compliance with the preceding sentence, the planning council may not designate (or otherwise be involved in the selection of) particular entities as recipients of any of the amounts provided in the grant.

(B) Required agreements

An individual may serve on the planning council under paragraph (1) only if the individual agrees that if the individual has a financial interest in an entity, if the individual is an employee of a public or private entity, or if the individual is a member of a public or private organization, and such entity or organization is seeking amounts from a grant under section 300ff–11(a) of this title, the individual will not, with respect to the purpose for which the entity seeks such amounts, participate (directly or in an advisory capacity) in the process of selecting entities to receive such amounts for such purpose.

(C) Composition of council

The following applies regarding the membership of a planning council under paragraph (1):

(i) Not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant under section 300ff–11(a) of this title, are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV/AIDS as determined under paragraph (4)(A). For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

(ii) With respect to membership on the planning council, clause (i) may not be construed as having any effect on entities that receive funds from grants under any of parts B through F of this subchapter but do not receive funds from grants under section 300ff–11(a) of this title, on officers or employees of such entities, or on individuals who represent such entities.

(6) Grievance procedures

A planning council under paragraph (1) shall develop procedures for addressing grievances with respect to funding under this subpart, including procedures for submitting grievances that cannot be resolved to binding arbitration. Such procedures shall be described in the bylaws of the planning council and be consistent with the requirements of subsection (c) of this section.

(7) Public deliberations

With respect to a planning council under paragraph (1), the following applies:

(A) The council may not be chaired solely by an employee of the grantee under section 300ff–11(a) of this title.

(B) In accordance with criteria established by the Secretary:

(i) The meetings of the council shall be open to the public and shall be held only after adequate notice to the public.

(ii) The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location.

(iii) Detailed minutes of each meeting of the council shall be kept. The accuracy of all minutes shall be certified to by the chair of the council.

(iv) This subparagraph does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters.

(c) Grievance procedures

(1) Federal responsibility

(A) Models

The Secretary shall, through a process that includes consultations with grantees under this subpart and public and private experts in grievance procedures, arbitration, and mediation, develop model grievance procedures that may be implemented by the planning council under subsection (b)(1) of this section and grantees under this subpart. Such model procedures shall describe the elements that must be addressed in establishing local grievance procedures and provide grantees with flexibility in the design of such local procedures.

(B) Review

The Secretary shall review grievance procedures established by the planning council and grantees under this subpart to determine if such procedures are adequate. In making such a determination, the Secretary shall assess whether such procedures permit legitimate grievances to be filed, evaluated, and resolved at the local level.

(2) Grantees

To be eligible to receive funds under this subpart, a grantee shall develop grievance procedures that are determined by the Secretary to be consistent with the model procedures developed under paragraph (1)(A). Such procedures shall include a process for submitting grievances to binding arbitration.

(d) Process for establishing allocation priorities

Promptly after the date of the submission of the report required in section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV/AIDS), the Secretary, in consultation with planning councils and entities that receive amounts from grants under section 300ff–11(a) or 300ff–21 of this title, shall develop epidemiologic measures—

(1) for establishing the number of individuals living with HIV/AIDS who are not receiving HIV-related health services; and

(2) for carrying out the duties under subsection (b)(4) of this section and section 300ff–27(b) of this title.

(e) Training guidance and materials

The Secretary shall provide to each chief elected official receiving a grant under section 300ff–11(a) of this title guidelines and materials for training members of the planning council under paragraph (1) regarding the duties of the council.

(July 1, 1944, ch. 373, title XXVI, § 2602, as added Pub. L. 101–381, title I, § 101(3), Aug. 18, 1990, 104 Stat. 577; amended Pub. L. 102–531, title III, § 312(d)(26), Oct. 27, 1992, 106 Stat. 3505; Pub. L. 104–146, § 3(b)(1), May 20, 1996, 110 Stat. 1347; Pub. L. 106–345, title I, §§ 101–102(c), 103, Oct. 20, 2000, 114 Stat. 1320–1323; Pub. L. 109–415, title I, §§ 106(b), 107(b), title VII, §§ 702(3), 703, Dec. 19, 2006, 120 Stat. 2780, 2783, 2820; Pub. L. 111–87, §§ 2(a)(1), (3)(A), 6(a), Oct. 30, 2009, 123 Stat. 2885, 2891.)

REFERENCES IN TEXT

Subpart II of part C of this subchapter, referred to in subsec. (b)(2)(J), was redesignated subpart I of part C of this subchapter by Pub. L. 106–345, title III, § 301(b)(1), Oct. 20, 2000, 114 Stat. 1345, and is classified to section 300ff–51 et seq. of this title.

The Social Security Act, referred to in subsec. (b)(4)(C)(v), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§ 1396 et seq.) and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 501 of the Ryan White CARE Act Amendments of 2000, referred to in subsec. (d), is section 501 of Pub. L. 106–345, which is set out as a note under section 300ff–11 of this title. Provisions relating to a report are contained in section 501(d) of Pub. L. 106–345.

PRIOR PROVISIONS

A prior section 2602 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

AMENDMENTS

2009—Pub. L. 111–87, § 2(a)(1), (3)(A), repealed Pub. L. 109–415, § 703, and revived the provisions of this section as in effect on Sept. 30, 2009. See 2006 Amendment note and Effective Date of 2009 Amendment; Revival of Section note below.

Subsec. (b)(4)(A). Pub. L. 111–87, § 6(a)(1), inserted '', as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status'' before semicolon.

Subsec. (b)(4)(B)(iii). Pub. L. 111–87, § 6(a)(2), added cl. (iii).

Subsec. (b)(4)(D)(iv). Pub. L. 111–87, § 6(a)(3), added cl. (iv).

2006—Pub. L. 109–415, § 703, which directed repeal of this section effective Oct. 1, 2009, was itself repealed by Pub. L. 111–87, § 2(a)(1), effective Sept. 30, 2009.

Pub. L. 109–415, § 702(3), substituted ''HIV/AIDS'' for ''HIV disease'' wherever appearing.

Pub. L. 109–415, § 107(b), substituted ''this subpart'' for ''this part'' wherever appearing.

Subsec. (b)(2)(G). Pub. L. 109–415, § 106(b), inserted '', members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C'' before ''and historically underserved groups''.

2000—Subsec. (b)(1). Pub. L. 106–345, §101(a)(1), substituted ‘‘demographics of the population of individuals with HIV disease in the eligible area involved,’’ for ‘‘demographics of the epidemic in the eligible area involved,’’.

Subsec. (b)(2)(C). Pub. L. 106–345, §101(a)(2)(A), inserted before semicolon at end ‘‘, including providers of housing and homeless services’’.

Subsec. (b)(2)(G). Pub. L. 106–345, §101(a)(2)(B), struck out ‘‘or AIDS’’ after ‘‘HIV disease’’.

Subsec. (b)(2)(K). Pub. L. 106–345, §101(a)(2)(C), struck out ‘‘and’’ after semicolon.

Subsec. (b)(2)(L). Pub. L. 106–345, §101(a)(2)(D), substituted ‘‘, including but not limited to providers of HIV prevention services; and’’ for period at end.

Subsec. (b)(2)(M). Pub. L. 106–345, §101(a)(2)(E), added subpar. (M).

Subsec. (b)(3)(C). Pub. L. 106–345, §103(1), struck out heading and text of subpar. (C). Text read as follows: ‘‘A planning council may not be chaired solely by an employee of the grantee.’’

Subsec. (b)(4)(A), (B). Pub. L. 106–345, §102(a)(2), added subpars. (A) and (B). Former subpars. (A) and (B) redesignated (C) and (D), respectively.

Subsec. (b)(4)(C). Pub. L. 106–345, §102(a)(1), redesignated subpar. (A) as (C). Former subpar. (C) redesignated (E).

Subsec. (b)(4)(C)(i) to (vi). Pub. L. 106–345, §102(a)(3), added cls. (i) to (vi) and struck out former cls. (i) to (iv) which read as follows:

‘‘(i) documented needs of the HIV-infected population;

‘‘(ii) cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available (either demonstrated or probable);

‘‘(iii) priorities of the HIV-infected communities for whom the services are intended; and

‘‘(iv) availability of other governmental and nongovernmental resources;’’.

Subsec. (b)(4)(D). Pub. L. 106–345, §102(a)(4), amended subpar. (D) generally. Prior to amendment, subpar. (D) read as follows: ‘‘develop a comprehensive plan for the organization and delivery of health services described in section 300ff–14 of this title that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease;’’.

Pub. L. 106–345, §102(a)(1), redesignated subpar. (B) as (D). Former subpar. (D) redesignated (F).

Subsec. (b)(4)(E), (F). Pub. L. 106–345, §102(a)(1), redesignated subpars. (C) and (D) as (E) and (F), respectively. Former subpar. (E) redesignated (G).

Subsec. (b)(4)(G). Pub. L. 106–345, §102(a)(1), (6)(A), redesignated subpar. (E) as (G) and substituted ‘‘public meetings (in accordance with paragraph (7)),’’ for ‘‘public meetings,’’.

Subsec. (b)(4)(H). Pub. L. 106–345, §102(a)(5), (6)(B), (7), added subpar. (H).

Subsec. (b)(5)(C). Pub. L. 106–345, §101(b), added subpar. (C).

Subsec. (b)(7). Pub. L. 106–345, §103(2), added par. (7).

Subsec. (d). Pub. L. 106–345, §102(b), added subsec. (d).

Subsec. (e). Pub. L. 106–345, §102(c), added subsec. (e).

1996—Subsec. (b)(1). Pub. L. 104–146, §3(b)(1)(A)(ii), inserted at end ‘‘Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard that is in accordance with paragraph (5).’’

Pub. L. 104–146, §3(b)(1)(A)(i), substituted ‘‘reflect in its composition the demographics of the epidemic in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations.’’ for ‘‘include representatives of—

‘‘(A) health care providers;

‘‘(B) community-based and AIDS service organizations;

‘‘(C) social service providers;

‘‘(D) mental health care providers;

‘‘(E) local public health agencies;

‘‘(F) hospital planning agencies or health care planning agencies;

‘‘(G) affected communities, including individuals with HIV disease;

‘‘(H) non-elected community leaders;

‘‘(I) State government;

‘‘(J) grantees under subpart II of part C of this subchapter; and

‘‘(K) the lead agency of any Health Resources and Services Administration adult and pediatric HIV-related care demonstration project operating in the area to be served.’’

Subsec. (b)(2). Pub. L. 104–146, §3(b)(1)(E), added par. (2). Former par. (2) redesignated (3).

Subsec. (b)(2)(C). Pub. L. 104–146, §3(b)(1)(B), added subpar. (C).

Subsec. (b)(3). Pub. L. 104–146, §3(b)(1)(D), redesignated par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (b)(3)(A). Pub. L. 104–146, §3(b)(1)(C)(i), substituted ‘‘area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—’’ for ‘‘area;’’ and added cls. (i) to (iv).

Subsec. (b)(3)(B). Pub. L. 104–146, §3(b)(1)(C)(ii), struck out ‘‘and’’ at end.

Subsec. (b)(3)(C). Pub. L. 104–146, §3(b)(1)(C)(iii), substituted ‘‘, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;’’ for period at end.

Subsec. (b)(3)(D), (E). Pub. L. 104–146, §3(b)(1)(C)(iv), added subpars. (D) and (E).

Subsec. (b)(4). Pub. L. 104–146, §3(b)(1)(D), redesignated par. (3) as (4).

Subsec. (b)(5), (6). Pub. L. 104–146, §3(b)(1)(F), added pars. (5) and (6).

Subsec. (c). Pub. L. 104–146, §3(b)(1)(F), added subsec. (c).

1992—Subsec. (a)(1). Pub. L. 102–531 substituted ‘‘Centers for Disease Control and Prevention’’ for ‘‘Centers for Disease Control’’.

EFFECTIVE DATE OF 2009 AMENDMENT; REVIVAL OF SECTION

For provisions that repeal by section 2(a)(1) of Pub. L. 111–87 of section 703 of Pub. L. 109–415 be effective Sept. 30, 2009, that the provisions of this section as in effect on Sept. 30, 2009, be revived, and that amendment by section 6(a) of Pub. L. 111–87 be applicable to this section as so revived and effective as if enacted on Sept. 30, 2009, see section 2(a)(2), (3) of Pub. L. 111–87, set out as a note under section 300ff–11 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–345, title VI, §601, Oct. 20, 2000, 114 Stat. 1355, provided that: ‘‘This Act [see section 1 of Pub. L. 106–345, set out as a Short Title of 2000 Amendments note under section 201 of this title] and the amendments made by this Act take effect October 1, 2000, or upon the date of the enactment of this Act [Oct. 20, 2000], whichever occurs later.’’

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–146 effective Oct. 1, 1996, see section 13 of Pub. L. 104–146, set out as a note under section 300ff–11 of this title.

§ 300ff–13. Type and distribution of grants

(a) Grants based on relative need of area

(1) In general

In carrying out section 300ff–11(a) of this title, the Secretary shall make a grant for each eligible area for which an application under section 300ff–15(a) of this title has been approved. Each such grant shall be made in an