



## Department of Health

**KATHY HOCHUL**  
Governor

**JAMES V. McDONALD, M.D., M.P.H.**  
Acting Commissioner

**MEGAN E. BALDWIN**  
Acting Executive Deputy Commissioner

### **Conditions for Participation in the Enhancing the Quality of Adult Living (EQUAL) Program 2023-2024**

Please carefully review the following as failure to adhere to these conditions may result in non-award under the EQUAL Program for funding year **2023-2024**.

#### **Conditions for Participation in the EQUAL Program**

The applicant (facility operator) agrees to the following conditions upon approval of this application:

1. Nothing contained herein or in any law shall create or be deemed to create any right, interest or entitlement for any individual or other entity eligible to participate under the program.
2. The applicant will be bound by the requirements, terms and conditions of the program as stated in statute and compliance with applicable Department of Health (“Department”) regulations, this Request for Applications, and other procedural requirements related to the program. This includes, but is not limited to, the timely completion of reports on the Health Commerce System such as census reports, financial reports, and all surveys applicable to Adult Care Facilities.
3. Payment of funds is subject to availability of funds specifically appropriated for such purpose.
4. The payment may be terminated in whole or in part by the Department.
5. As a condition of receiving EQUAL funds, the applicant shall warrant that it is not in arrears to the State upon debt or contract, and is not a defaulter as surety, contractor or as to any other obligation to the State.
6. As a condition of receiving EQUAL funds, the applicant shall warrant that it does not intend to/or anticipate facility closure within twelve months of payment. The facility will be required to submit both completed Exhibit A and Exhibit B with PDF copies of all relevant receipts for any used funds and return any unused EQUAL funds to the Department if closure occurs.
7. EQUAL payments shall be made for the purpose of enhancing both residents’ quality of care and life experience in the adult care facility. Funds will not be awarded to subsidize daily operational expenses such as staffing or utilities. Funding is available as follows:

**Local Assistance Projects** *These funds are used to support improvements to the quality of life for adult care facility residents. Allowable expenses include, but are not limited to:*

- clothing allowances or shopping trips;
- resident specific computer and television purchases;
- upgraded resident bedding;
- resident training to support independent living skills;
- improvements in food quality (e.g., featured menus, culinary events, or small appliances);

- outdoor leisure projects (i.e., supplies for outdoor events/activities);
- staff training other than regulatorily required training;
- the cost of transportation for resident services/events (e.g., bus rental, gas, tolls, mileage); and
- cultural, recreational, and other leisure events.

Such expenditures shall not be used to supplant the facility's legal or regulatory obligations.

**Capital Improvement Projects** *These funds are used to enhance the physical environment of the facility and promote a higher quality of life for residents. Allowable expenses include, but are not limited to:*

- aesthetic and/or structural facility upgrades (e.g., painting, carpeting artwork, furniture);
- shared electronics (resident common area televisions, computers, or shared iPads);
- built in appliances (for resident use);
- outdoor leisure space (e.g. building/installing and furnishing patios, gazebos, and/or community gardens);
- air conditioning for resident areas; and
- enhancement or expansion of resident areas.

Such expenditures shall not be used to supplant the obligations of facility operator to provide a safe, comfortable living environment for residents in a good state of repair and sanitation.

The above are not exhaustive lists of allowable expenses. The Department will review each proposal for the acceptable use of program funds. Final approval resides with the Department.

8. EQUAL payments must be expended within twelve months of payment on the intended use(s). **Expenditures outside of the approved spending plan are not permitted. The Department's approval, demonstrated by a signed Attachment 2: EQUAL Budget Modification, is required prior to any changes to be made in the approved Expenditure Plan and must include documentation to demonstrate resident council approval or, in the absence of a residents' council, approval from a minimum of three (3) SSI/SSP/SN and/or Medicaid (with respect to residents of assisted living programs) recipient residents to demonstrate that they were a part of the decision-making process and are in agreement with the proposed changes.** Note: Enriched Housing programs that do not have a resident council must maintain on file a signed petition similar to the form attached at the end of these instructions. In all circumstances, such agreement shall **clearly** demonstrate that SSI/SSP/SN residents agree with the proposed plan.
9. EQUAL funds may not be used for expenses incurred retrospectively except that expenditures may be incurred prior to the approval of the facility's application for such fiscal year, provided that: (a) consistent with subdivision three of this section, the residents' council approves such expenditure prior to the expenditure being incurred, and the facility provides with its application documentation of such approval and the date thereof; and (b) the expenditure meets all applicable requirements pursuant to this section and is subsequently approved by the Department.

10. Payments shall be determined as follows:

**Not Eligible** - Any facility that has not fully complied with the Application Instructions and does not meet the application deadline will be deemed non-responsive. As such, the application will not be reviewed and the facility will not be eligible for funding. Likewise, any facility that indicates intent to close within the next twelve (12) months will not be considered eligible for funding and the application will not be considered for further review.

Facilities that do not have residents in receipt of SSI/SSP/SN or Medicaid (with respect to assisted living programs) will be deemed ineligible for funding.

The Department may deny any operator that has received official written notice from the Department of a proposed revocation, suspension, limitation or denial of the operator's operating certificate; or proposed assessment of civil penalties; or issuance of a Department Order, the seeking of equitable relief; or the issuance of a Commissioner's Order. A facility that has received an enforcement notification will not necessarily be denied EQUAL funding this year unless the enforcement notice is for a non-rectifiable endangerment violation as outlined in 18 NYCRR § 486.5(a)(4)(i)-(vi).

Facilities with open plans of correction related to prior EQUAL funding, those that appear on the Department's Do Not Refer List, and/or those on the Office of the Medicaid Inspector General's Exclusion List will not be eligible for EQUAL Funding.

Further, facilities receiving an Intent to Award letter but do not submit complete proposed spending plans by the required deadline will be deemed ineligible to receive EQUAL funding.

11. The Department may, at any time, reassess the continued eligibility of an operator to receive an EQUAL payment by failing to meet compliance standards on an ongoing basis.
12. Records related to expenditures made under the EQUAL Program must be maintained and made available to the Department or its agents upon request for audit purposes. The Department reserves the right to audit expenditures at any time to ensure compliance. Such records, including Exhibits A and/or B, must be kept available for review at the facility for a period of at least seven (7) years.
13. This application for EQUAL, and any payments resulting from such application, are subject to all laws, rules and regulations promulgated by any federal, state and municipal authority having jurisdiction as the same and may be amended from time to time. The Department reserves its rights in its sole discretion, to modify and/or withdraw this application at any time. All applications are prepared at the sole risk, cost, and expense of the applicant.
14. Submission of an EQUAL application does not commit the Department to award any payment, to pay any costs incurred in the preparation of responses to such applications, or to procure or contract for any services.
15. The Department reserves the right to amend, modify or withdraw the EQUAL Program application and to reject any applications submitted; and may exercise such right at any time without notice and without liability to any applicant or other parties for their expenses incurred in the preparation of an application or otherwise. Amendments will be prepared at the sole cost and expense of the applicant.

16. The Department reserves the right to award payments to as many or as few applicants as it may select, to accept or reject any or all proposals which do not completely conform to the instructions and statutory requirements, and to cancel, in whole or in part, the EQUAL Program applications, if the Department, in its sole discretion, deems it to be in its best interest to do so.
17. Submission of an application will be deemed to be the consent of the applicant to any inquiry made by the Department of third parties with regard to the applicant's character, competence, experience or other matters relevant to the proposal.
18. The Department reserves the right to request and consider additional information from any applicant beyond that requested via the application or presented in the initial proposal. A payment, if any, may be made on condition of the receipt of any additional information requested.
19. Upon notification of intent to award, the facility must submit a **2023-2024** EQUAL Proposed Spending Plan, along with an approval statement signed by the resident council or, where there is no resident council, a minimum of three (3) SSI/SSP/SN and/or Medicaid (with respect to residents of assisted living programs) recipient residents verifying approval of the spending plan. These submissions must be received via [equal@health.ny.gov](mailto:equal@health.ny.gov) within thirty (30) calendar days of the date of the Intent to Award Letter. Failure to submit may be deemed forfeiture of your award and funding may be reallocated to other awardees pursuant to the Department funding methodology.
20. Payments under this program will not be processed until all information requested has been received and approved. All issues must be finalized to the satisfaction of the Department before a payment can be authorized. The Department is not liable for any expenses incurred before a payment is issued.
21. The Department reserves the right to negotiate any aspect of the proposal and if negotiations fail to result in a satisfactory agreement, terminate negotiations or take such action as the Department may deem appropriate.
22. The application shall be electronically signed and submitted by an official (Administrator) of the facility authorized to bind the applicant(s). The application shall provide the name(s) of individuals with authority to negotiate and contractually bind the facility. The application will also include, the name, email address, telephone number (including area code) of the facility's contact person.
23. The Department may require reports to be submitted relating to obligations incurred, expenditures made, payments received, and services provided under the EQUAL Program. All reports shall be in such form and detail and shall be submitted at such times as the Department shall prescribe.
24. The successful applicant will permit, and shall require its agents, contractors and employees to permit, duly authorized representatives of the Department and the Office of the State Comptroller to inspect all work, materials, records, invoices and other relevant data and records, and to audit the books, records and accounts of the applicant and its agents, contractors and employees pertaining to the EQUAL Program, and for a period of seven (7) years after its termination.

25. If an audit or inspection shows that any item of work for which a disbursement was made was not carried out in full compliance with the terms and conditions of the EQUAL Program, the applicant shall, upon demand of the Department, remit payment to the Department at the specified amount and/or complete or correct the cited deficiency within the time period specified by the Department.
26. The Applicant and the Department agree that the Applicant is an independent entity and not an employee or agent of the Department. The Applicant agrees to indemnify the Department and the State of New York against any loss the Department or the State of New York may suffer when such losses result from claims of any person or organization (excepting the Department and State of New York) injured by the negligent acts or omission of the Applicant, its agents, and/or employees or contractors.
27. All reported information is subject to verification. Falsification of reported information may result in disqualification from the program and/or legal proceedings against the facility operator.

### **Components of the EQUAL Application**

Please review and ensure compliance with all application components described below. Failure to submit all necessary components as instructed may deem an application ineligible for review.

Sections A – E must all be submitted electronically through the Health Commerce System:

- **Section A: Acknowledgement of Participation**
- **Section B: Facility Information**
- **Section C: Payment Information**
- **Section D: Population Served**  
Provide data on residents currently receiving SSI, SSP, SN support and/or Medicaid (with respect to residents of assisted living programs). Those residents receiving a combination of services must only be counted once.
- **Section E: Certifications and Confirmations**  
The Facility must provide information, confirmation and certifications regarding previous EQUAL funding, resident involvement in the development and approval of the proposed **2023-2024** EQUAL Spending Plan, and certification of proper use of EQUAL funding. Confirmation of submission of necessary attachments is also required.

### **Other Funding Requirements**

Effective January 1, 2012, to do business with New York State, a facility must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and to initiate a contract with the Department, vendors must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

**Please note: A SFS Vendor ID Number is a required application component. Failure to include the correct SFS Vendor ID Number will result in non-award.**

If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at: [http://www.osc.state.ny.us/vendor\\_management/forms.htm](http://www.osc.state.ny.us/vendor_management/forms.htm).

Additional information concerning the New York State Vendor File can be obtained on-line at: [http://www.osc.state.ny.us/vendor\\_management/index.htm](http://www.osc.state.ny.us/vendor_management/index.htm), by contacting the SFS Help Desk at (855) 233-8363 or by emailing at [helpdesk@sfs.ny.gov](mailto:helpdesk@sfs.ny.gov).

**Reporting and Other Required Documentation upon Award:**

- **ATTACHMENT 1:** The EQUAL Proposed Spending Plan must be submitted within 30 calendar days of receipt of an award letter via email to [equal@health.ny.gov](mailto:equal@health.ny.gov) with a subject line of “*Facility Name 2023-2024 EQUAL Proposed Spending Plan*”.

Failure to submit Attachment 1 in the above manner, will be considered forfeiture of a facility’s EQUAL award. Funds may be reallocated to other awarded facilities pursuant to the Department’s funding methodology.

- Facilities with a resident council, must complete the Resident Council Representative Approval of Proposed Spending Plan section of their EQUAL Proposed Spending Plan (within 30 calendar days of an award letter).
- Facilities that do not have a resident council must complete the Resident Petition in Support of Proposed Spending Plan section of the Proposed Spending Plan (within 30 calendar days of an award letter).
- **EXHIBIT A:** Payment and Expenditure Tracking Form (to be completed as expenses are incurred, maintained on file by the facility, and presented to the Department upon request).
- **EXHIBIT B:** EQUAL Program Certification Page (to be completed, certified, and submitted by the facility upon expenditure of EQUAL funds).

**Exhibits A and B must be** submitted to the Department upon disbursement of all EQUAL funds with a PDF copy of all applicable receipts no later than twelve months (one year) from date of award.

\*Failure to submit the required and/or any requested documentation may deem the facility ineligible for future funding opportunities.

Questions may be referred to the EQUAL Program via email to [equal@health.ny.gov](mailto:equal@health.ny.gov).

**Budget Modifications**

If a change to an approved Spending Plan is desired, the facility must submit a budget modification request, with documented resident consent, via email to [equal@health.ny.gov](mailto:equal@health.ny.gov) using Attachment 2 of the EQUAL Instructions. Submission of such request does not guarantee Department approval and failure to secure such approval is done at the facility’s risk.

**EQUAL 2023-2024 Proposed Spending Plan**

For submission to [equal@health.ny.gov](mailto:equal@health.ny.gov) no later than 30 calendar days from the date of a New York State Department of Health Award Letter.

<b>Capital Improvement Projects</b>	<b>Amount Awarded:</b>
<i>These funds are used to enhance the physical environment of the facility and promote a higher quality of life for residents.</i>	

<b>Local Assistance Projects</b>	<b>Amount Awarded:</b>
<i>These funds are used to support improvements to the quality of life for adult care facility residents by funding projects including clothing allowances, resident training to support independent living skills, improvements in food quality, outdoor leisure projects, and cultural, recreational and other leisure events.</i>	

**Total Amount of Funding:** \_\_\_\_\_

**Summary Budget**

This form should be used by applicants to provide a detailed budget justification. For each line item provide a full description of the item, justification of the need for the item as it relates to the resident priorities identified and explanation of how costs were determined. *Additional pages may be added but must all conform to this format and include the Resident Council Representative Approval or Resident Petition in Support.*

Budget Line Items	Capital Improvement Project Funds Requested	Local Assistance Project Funds Requested
<b>Total Requested Per Funding Source</b>		
<b>Total Funding Requested</b>		

○ **RESIDENT COUNCIL REPRESENTATIVE APPROVAL:** I, \_\_\_\_\_ (name of representative), have reviewed the Proposed EQUAL 2023-2024 Spending Plan for \_\_\_\_\_ (name of facility), \_\_\_\_\_ (operating certificate #), and agree that the proposed use of these funds is consistent with the priorities of SSI/SSP/SN and/or Medicaid (ALP) residents' priorities.

○ **RESIDENT PETITION IN SUPPORT:** We, the undersigned, are SSI/SSP/SN and/or Medicaid (ALP) recipients residing at \_\_\_\_\_ (name of facility), \_\_\_\_\_ (operating certificate #). We have reviewed the Proposed EQUAL 2023-2024 Spending Plan and agree that the proposed use of funds is consistent with our priorities.

Resident Name: \_\_\_\_\_ Resident Name: \_\_\_\_\_ Resident Name: \_\_\_\_\_  
 Resident Signature: \_\_\_\_\_ Resident Signature: \_\_\_\_\_ Resident Signature: \_\_\_\_\_

## EQUAL MODIFICATION REQUEST FORM

For each requested modification below, include a justification as to why the residents and facility have decided not to/cannot expend the EQUAL funding as requested and how the proposed modification will enhance the quality of live and/or life experience of the eligible residents (add additional pages if needed).

Facility \_\_\_\_\_

Operating Certificate # \_\_\_\_\_

Facility Contact Name & Number \_\_\_\_\_ EQUAL Program Year \_\_\_\_\_

Budget Line Item*	EQUAL Approved Expenditures	Change +/-	Revised EQUAL Expenditures	Narrative Justification
				Provide as much detailed information as possible.
Capital Improvement Projects			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
<b>Subtotal:</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	



	<b>EQUAL Approved Expenditures</b>	<b>Change +/-</b>	<b>Revised EQUAL Expenditures</b>	<b>Narrative Justification</b>
<b>Local Assistance Projects</b>				<b>Provide as much detailed information as possible.</b>
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	
			\$0.00	<b>Attach additional sheets as necessary</b>
<b>Subtotal:</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	
<b>GRAND TOTAL</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	

\* Include all approved EQUAL Expenditures, even if you are not requesting a change to that budget item

**Authorized Facility Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Resident Council Representative:** I have reviewed the proposed budget modification above and agree that the proposed use of these funds is consistent with the priorities of SSI/SSP/SN and/or Medicaid (ALP) residents' priorities.

Resident Council Representative Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Resident Petition in Support:** We, the undersigned, are SSI/SSP/SN and/ or Medicaid (ALP) recipients residing at \_\_\_\_\_ (name of facility), \_\_\_\_\_ (operating certificate #). We have reviewed the Proposed EQUAL 2021-2022 Spending Plan and agree that the proposed use of funds is consistent with our priorities.

Resident Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Resident Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Resident Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NYSDOH Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2023-2024 EQUAL Payment and Expenditure Tracking Form**

<b>Capital Improvement Projects</b>	<b>Total Award Amount</b>		<b>\$</b>	
<b>Budget item</b>	<b>Approved Budget Amount</b>	<b>Date of Expenditure</b>	<b>Amount Spent</b>	<b>Balance</b>
<b>Total Capital Improvement Funds Spent &amp; Balance Available</b>			<b>\$</b>	<b>\$</b>

<b>Aide to Localities (ATL)</b>	<b>Total Award Amount</b>		<b>\$</b>	
<b>Budget item</b>	<b>Approved Budget Amount</b>	<b>Date of Expenditure</b>	<b>Amount Spent</b>	<b>Balance</b>
<b>Total ATL Funds Spent &amp; Balance Available</b>			<b>\$</b>	<b>\$</b>

I certify that all expenditures reported (or payments requested) are for appropriate purposes and in accordance with the agreement set forth in the application and executed contract.

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EQUAL PROGRAM CERTIFICATION PAGE**

**Statement regarding expenditure of funds:**

I certify that funds granted under the EQUAL Program were used for the purpose(s) stated in Section C (a) of my EQUAL **2023-2024** application and approved by the New York State Department of Health. I certify that any changes in the submitted plan of work and/or budget were submitted in writing to the New York State Department of Health and approved. I further certify compliance with Subdivision 1-4 of Section §461-S of the Social Service law.

**Statement regarding records management:**

I certify that records related to expenditures under EQUAL **2023-2024** will be maintained by the facility for a period of at least seven years and made available for review for audit purposes upon request by the New York State Department of Health.

**Statement regarding project status and financial expenditure reports:**

I agree to submit financial expenditure reports as requested by the New York State Department of Health. I also agree to account for all grant funds, to maintain separate financial and programmatic records on this project, and to retain such source documentation as canceled checks, paid bills, payroll, or other accounting documentation that would facilitate an audit. I understand that failure to submit the status and financial reports will result in this facility becoming ineligible to receive future EQUAL Program funding, until such time that the delinquent reports have been successfully submitted.

**NOTARIZATION:**

Operator's Signature \_\_\_\_\_

STATE OF NEW YORK  
COUNTY OF ( \_\_\_\_\_ ) ss.: \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me personally came

\_\_\_\_\_ to me known, who being

sworn did depose and say that he/she resides in \_\_\_\_\_

that he/she is the \_\_\_\_\_ of \_\_\_\_\_  
Facility Name & Operating Certificate #

Adult Care Facility described herein, and which executed the above instrument.

\_\_\_\_\_  
NOTARY PUBLIC My Commission Expires \_\_\_\_\_  
DATE