Conditions for Participation in the
Enhancing the Quality of Adult Living (EQUAL) Program 2026-2027

Please carefully review the following, as failure to adhere to these conditions may result in non-award for funding year 2026-2027.

Conditions for Participation

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 application, and other procedural requirements related to the program. This includes, but is not limited to, the timely completion of reports, 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 funding, 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 funding, 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 a completed Exhibit A and Exhibit B with PDF copies of all relevant receipts for any used funds and return any unused or misappropriated funds to the Department if closure occurs.

7. All unspent or unused funding must be returned to the Department immediately following the twelve (12) month spending period. Repayment should be sent in the form of a check made out to The New York State Department of Health, with a memo noting "EQUAL 2026-27 Returned Funds" and sent via mail to the address below. Included with the check should be current copies of Exhibit A and Exhibit B.

New York State Department of Health
Division of Residential Support
875 Central Avenue
Albany, New York 12206
Attn.: EQUAL Coordinator

8. 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. Facilities must meet with eligible residents to review the anticipated award and develop a proposed spending plan, with Resident Approval. EQUAL is not a cash award. The Department reserves the right to deny funding for any expenditure that does not support the health and well-being of community members (i.e., tobacco, alcohol, firearms, etc.). 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, outside of those that are regulatorily required;
- the cost of transportation for resident services/events (e.g., bus rental, gas, tolls, mileage); and
- cultural, recreational, and other leisure events.

Facilities that provide resident "stipends" or "clothing allowances" must implement measures to demonstrate appropriate use of funding in case of an audit.

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 the 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 all proposals for the acceptable use of program funds with final approval residing with the Department.

Payments should be expended within twelve (12) months of payment on the intended use(s). **Expenditures outside of the approved spending plan are not permitted.** No changes in spending can be made outside Department approval. Such requests must be submitted within six (6) months of the original approved plan. Any request received beyond the six (6)

months may be reviewed at the Department's discretion and will require a clear justification outlining the need and why the facility could not submit within the required six (6) month period. 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 eligible residents agree with the proposed plan.

Submission of a Budget Modification Request does not mean approval. All submissions will be reviewed by the Department, and formal determination will be issued by the Department. **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 spending plan.**

9. Funds should 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) 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. Non-responsive applications 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 be considered ineligible for funding and the application will not be considered for further review.

Facilities that do not have residents receiving Supplemental Security Income, State Supplemental Program benefits, Safety Net assistance, and/or Medicaid (with respect to residents of 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 funding unless the enforcement notice is for a non-rectifiable endangerment violation as outlined in 18 NYCRR 486.5(a)(4)(i)-(vi).

Facilities with unanswered/unacceptable plans of correction related to prior funding, owe the Department repayment for unused/misappropriated 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.

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

11. The Department may, at any time, reassess the continued eligibility of an operator to receive a payment by failing to meet compliance standards on an ongoing basis.

12. Records related to expenditures must be maintained and made available to the Department for audit purposes. The Department reserves the right to audit expenditures at any time to

ensure compliance. Such records, including Exhibit A and Exhibit B and receipts, must be kept available for review at the facility for a period of at least seven years.

13. This application 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 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 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 regarding 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 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, using Attachment 1, the facility must electronically complete and submit a proposed spending plan, with completed Resident Approval.

    Where there is no resident council, a minimum of three SSI/SSP/SN and/or Medicaid (with respect to residents of assisted living programs) recipient residents must verify approval of the spending plan.

    Submissions must be received within thirty (30) calendar days of the date of the Intent to Award Letter. Failure to submit will result in an incomplete application and deemed forfeiture of the award. Funding may be reallocated to other awardees pursuant to the Department funding methodology.

    If the proposed plan includes disallowable expenses or otherwise requires revisions, you will be afforded a onetime revision allowance. You will have fifteen (15) days from the date of notice by the Department to reply. Failure to submit an approvable plan within the deadline may result in a reduction of, or rescinding of, your award. All submissions must include the Resident Approval. The Department reserves the right to remove any disallowable expenses and to reduce or rescind awards accordingly.

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 as to 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 contact person for the facility.

23. The Department may require reports to be submitted relating to obligations incurred, expenditures made, payments received, and services provided. 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 for a period of seven years after its termination.

25. If an audit or inspection shows that any item of work for which a disbursement has been made was not carried out in full compliance with the terms and conditions, the applicant shall, upon demand of the Department, repay such payment to the Department and/or complete or correct the cited deficiency within the time 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 and B must be submitted electronically.

- **Section A: Acknowledgement of Participation**
  The facility must confirm that they do not anticipate closure within the next twelve (12) months, are not on the Department's Do Not Refer List, are not on the Office of the Medicaid Inspector General's Exclusion List, do not have any unanswered or

unacceptable plans of correction related to past EQUAL awards, do not owe the Department any money for unused/unspent EQUAL awards, and has eligible residents. The facility must also provide its confirmed Statewide Financial Systems Vendor Identification Number and upload proof of Vendor Identity.

To obtain proof of Statewide Financial System Vendor Identity, applicants must log into the Statewide Financial System, select the *View Locations* tile, click the appropriate hyperlinked vendor ID to open *Current Locations*, verify the account information, print or screenshot a copy, and attach the document to their proposed Spending Plan. Applicants must address any identified discrepancies in Vendor ID, Payee Name and/or Address prior to submission. Questions can be directed to HelpDesk@sfs.ny.gov. **Submissions that do not include proof of Vendor Identity will be deemed incomplete and ineligible for funding. Therefore, the Department suggests that all applying facilities access the Statewide Financial System early in the application process and address any access issues and discrepancies with the HelpDesk@sfs.ny.gov. Extensions will not be granted.**

- **Section B: Certifications and Confirmations**

The facility must confirm that funding received will be used for the purposes indicated on the Proposed Spending Plan which will be submitted to the Department by the deadline outlined in the Intent to Award Letter, that any negative audit findings may require repayment to the department and/or completion of correction of cited deficiencies within the timeframe specified by the department, and that any unused/unspent funding must be returned to the Department with hard copies of Exhibits A and B.

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, 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 Statewide Financial System Vendor ID Number is a required application component. Failure to include the correct Vendor ID Number, with proof of Vendor Identity, 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.

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, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

Reporting and Other Required Documentation upon Intent to Award:

ATTACHMENT 1: Must be submitted, with Resident Approval, within thirty (30) calendar days of receipt of an award

Failure to submit Attachment 1, with Resident Approval, will be considered an incomplete application and forfeiture of a facility's 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 the Resident Approval (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 Resident Approval (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 and upon expenditure of funding).

- **EXHIBIT B:** EQUAL Program Certification Page (to be completed, certified, and submitted by the facility upon expenditure of funding).

Exhibit A and Exhibit B must be submitted to the Department upon disbursement of all funding no later than twelve (12) months (one year) from date of payment.

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

Questions must be submitted via email to ltcresidentialsupport.equal@health.ny.gov.

Budget Modifications

If a change to an approved spending plan is needed, the facility must submit a budget modification request, with documented resident consent, via email to ltcresidentialsupport.equal@health.ny.gov using Attachment 2 of the Application Instructions. Changes are subject to Department review and approval. A formal determination will be issued by the Department. No changes in spending can be made outside Department approval. Such requests must be submitted within six (6) months of the original approved plan. Any request received beyond the six (6) months may be deemed untimely and not reviewed. However, the Department may, at its discretion, review such submissions in so far as a clear justification outlining the need and reasons that a request could not be submitted within the required six (6) month is provided.

Attachment 1 Page 1 of _____

EQUAL 2026-2027 Proposed Spending Plan

The Proposed Spending Plan must be submitted no later than thirty (30) calendar days from the date of a New York State Department of Health Intent to Award Letter. Submission does not guarantee approval. All submissions will be reviewed by the Department.

Funds will not be awarded to subsidize daily operational expenses such as staffing or utilities. EQUAL is not a cash award. The Department reserves the right to deny funding for any expenditure that does not support the health and well-being of community members (i.e., tobacco, alcohol, firearms, etc.). 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, outside of those that are regulatorily required;
- the cost of transportation for resident services/events (e.g., bus rental, gas, tolls, mileage); and
- cultural, recreational, and other leisure events.

Facilities that provide resident “stipends” or “clothing allowances” must implement measures to demonstrate appropriate use of funding in case of an audit. **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 the 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 all proposals for the acceptable use of program funds with final approval residing with the Department.

Payments should be expended within twelve (12) months of payment on the intended use(s). **Expenditures outside of the approved spending plan are not permitted.**

*Should your proposed plan include disallowable expenses or otherwise require revisions, you will be afforded a **onetime** revision allowance. You will have fifteen (15) days from the date of notice by the Department to respond. Failure to submit an approvable plan within the deadline may result in a reduction of, or rescinding of, your award. All submissions must include the Resident Council Representative Approval or Resident Petition in Support.*

The Department reserves the right to remove any disallowable expenses and reduce or rescind awards accordingly.

Facility Name:_____
Submitted By:_____
Email:_____ Phone:_____

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

Local Assistance Projects	**Amount Awarded:**
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.	

Total Amount of Funding: _____

Summary Budget
The Summary Budget must be completed by applicants to provide a detailed budget justification. Please review DAL_DRS 26-03_Instructions before completing the Summary Budget to ensure that you are requesting allowable expenses. 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
Total Requested Per Funding Source		
Total Funding Requested		

Resident Approval (INSERT LINK) is **REQUIRED** to complete the submission of your proposed Spending Plan. Please ensure that your proposed plan is developed with, and reviewed by, eligible residents with approval demonstrated by completion of the Resident Approval form. This form is completed and uploaded prior to submission.

This form is considered incomplete without Resident Approval.
Failure to submit, with Resident Approval, by the deadline established in the Intent to Award Letter will be considered an incomplete submission and forfeiture of the anticipated award

Attachment 2

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* **Capital Improvement Projects**	**EQUAL Approved Expenditures**	**Change +/-**	**Revised EQUAL Expenditures**	**Narrative Justification** **Provide as much detailed information as possible.**
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
Subtotal:	**$0.00**	**$0.00**	**$0.00**	
Local Assistance Projects		**Change**		

	EQUAL Approved Expenditures	+/-	Revised EQUAL Expenditures	Narrative Justification Provide as much detailed information as possible.
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	
			$0.00	**Attach additional sheets as necessary**
Subtotal:	**$0.00**	**$0.00**	**$0.00**	
GRAND TOTAL	**$0.00**	**$0.00**	**$0.00**	

*** 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 budget modification above 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:_____

EXHIBIT A Page 1 of _____

2026-2027 EQUAL Payment and Expenditure Tracking Form

Capital Improvement Projects	**Total Award Amount**		**$**	
Budget item	**Approved Budget Amount**	**Date of Expenditure**	**Amount Spent**	**Balance**
Total Capital Improvement Funds Spent & Balance Available			**$**	**$**

Aide to Localities (ATL)	**Total Award Amount**		**$**	
Budget item	**Approved Budget Amount**	**Date of Expenditure**	**Amount Spent**	**Balance**
Total ATL Funds Spent & Balance Available			**$**	**$**

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_____

EXHIBIT B

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 the EQUAL 2026-2027 Dear Administrator Letter and Instructions, my application and the spending plan 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 Section § 461-S of the Social Services Law.

Statement regarding records management:

I certify that records related to expenditures under EQUAL 2026-2027 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.

_____ My Commission Expires _____
NOTARY PUBLIC DATE