NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 3, 2024

Sent via email/Certified Mail:
The Pavilion at Vestal
105 West Sheedy Road
Vestal, New York 13850
nsantos@vestalparkrehab.com

Re: 2024-25 EQUAL Intent to Award

Dear Administrator/Operator:

The New York State Department of Health ("Department") is pleased to notify you of the intent to award The Pavilion at Vestal in response to your 2024-25 EQUAL Program application. Please note, this is not confirmation of an award; to receive your funding, you must complete and submit a proposed Spending Plan by **January 10, 2025**. Upon receipt, your proposed Spending Plan will be reviewed and upon approval, a formal funding notice will be issued.

Please review with your eligible residents the anticipated award outlined below to identify how to utilize the full award value. Upon completion, please submit Attachment 1: EQUAL 2024-25 Proposed Spending Plan with either Resident Council Representative Approval or, in the event your facility does not have a formalized Resident Council, Resident Petition in Support (enclosed for ease of reference).

The anticipated award will be funded as follows:

Capital Improvement Projects: $47,922.50
These funds are used to enhance the physical environment of the facility and promote a higher quality of life for residents.

Local Assistance Projects: $47,922.50
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.

Failure to submit your complete, proposed Spending Plan by the designated deadline will result in forfeiture of your award. Your proposed Spending Plan must be received by **January 10, 2025,** via email to ltcresidentialsupport.equal@health.ny.gov. Please note, no alternative method of submission is accepted. Due to its time sensitivity, the Department will confirm receipt of the proposal within 24 hours of receipt; if you do not receive a confirmation of receipt, please resubmit. The Department is unable to issue due date reminders to facilities.

If you have any questions, please send an email to ltcresidentialsupport.equal@health.ny.gov.

Sincerely,

Kristen M. Pergolino, Director
Division of Residential Support

cc: K. Anderson
K. Walker
John Van Dyke
EQUAL File

Attachment 1

EQUAL 2024-2025 Proposed Spending Plan

Summary Budget
This form must 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
Appliances	$10,000.00	
furniture	$ 20,000.00	
Garden/ Landscaping	$ 17,992.50	
Catering/Events		$35,000.00
Activities/ supplies		$12,992.50
Total Requested Per Funding Source	$ 47,992.50	$47,992.50
Total Funding Requested	$95,985.00	

- **RESIDENT COUNCIL REPRESENTATIVE APPROVAL:** I, Patricia Ciganek (name of representative), have reviewed the Proposed EQUAL 2024-2025 Spending Plan for The Pavilion at Vesta (name of facility), 030-F-058 (operating certificate #), and agree that the proposed use of these funds is consistent with the priorities of SSI/SSP/SN residents' priorities.
  Signed Patricia Ciganek

- **RESIDENT PETITION IN SUPPORT:** We, the undersigned, are SSI/SSP/SN recipients residing at _____(name of facility), _____(operating certificate #). We have reviewed the Proposed EQUAL 2024-2025 Spending Plan and agree that the proposed use of funds is consistent with our priorities.

Resident Name:_____ Resident Signature:_____
Resident Name:_____ Resident Signature:_____
Resident Name:_____ Resident Signature:_____

APPROVED 2024-2025 EQUAL

Digitally signed by APPROVED 2024-2025 EQUAL
Date: 2025.02.10 15:27:04 -05'00'

Attachment 1

EQUAL 2024-2025 Proposed Spending Plan

This form must be submitted to ltcresidentialsupport.equal@health.ny.gov *no later than thirty (30) calendar days from the date of a New York State Department of Health Award Letter. Submission does not mean approval. All submissions will be reviewed by the Department.*

Should your proposed plan include disallowable expenses or otherwise required revisions, you will be afforded a ***one-time*** *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 to, 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.

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.	$ 47,992.50

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.	$ 47,992.50

Total Amount of Funding: $ 95,985.00

Attachment 1

EQUAL 2024-2025 Proposed Spending Plan

INCOMPLETE WITHOUT RESIDENT(S) SIGNATURE(S)