

**New York State Department of Health
Division of Adult Care Facility/Assisted Living Surveillance
Conditions for Participation in the
Enhancing the Quality of Adult Living (EQUAL) Program 2020-2021**

Conditions for Participation in the EQUAL 2020-2021 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 (HCS), 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 the 2020-2021 calendar year. 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 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.

Use of program funds may include, but shall not be limited to:

- air conditioning
- furnishings
- clothing allowance for residents (gift cards are preferred to facilitate resident choice)
- upgrades to resident room furnishings
- resident activities and/or community outings
- computers and televisions for resident use
- transportation for resident services
- all other expenses designed for improving the residents' life experience beyond the day to day operational programs and services
- equipment
- staff trainings
- expenditures related to a corrective action as required by the most recent inspection report
- emergency disaster preparedness, such as generators, electronic health records, resident tracking systems, transition programs, and vehicles used for evacuations

- maintenance or repairs to the facility (the Operator is required to check with their Regional Office to determine if a Resident Safety Plan is required prior to initiating work)

The above is not an exhaustive list of allowable expenses. The Department will review all proposals for the acceptable use of program funds with final approval residing with the Department.

8. EQUAL payments should be expended within twelve months of receipt of your check on the intended use(s). **Prior approval by the Department is required for 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) 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.
9. EQUAL 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) 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 - 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; 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 486.5(a)(4)(i)-(vi).
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 for audit purposes. The Department reserves the right to audit expenditures at any time to ensure compliance. Such records include Exhibit must be kept available for review at the facility for a period of at least seven 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 or presented in the initial proposal. A payment, if any, may be made on condition of the receipt of any additional information requested.
19. 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.
20. The facility must submit a 2020-2021 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 residents verifying approval of the spending plan verifying approval of the spending plan (Section E: Attachments 1,2, & 3, respectively). These Attachments must be submitted via email to EQUAL@health.ny.gov. Applicants must also submit a certification statement demonstrating Original signed attestation forms must remain on file at the facility.
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 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 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 of the EQUAL Program, 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 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 the three (3) application components described below. Failure to submit all necessary components as instructed may deem your application ineligible for review.

- **Sections A – D:** To be completed and electronically submitted 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:** To be completed and submitted to the EQUAL Bureau Mail Log at equal@health.ny.gov. Includes:
 - The facility must submit either a copy of their Resident Council Representative Approval of Proposed Spending Plan (Attachment 1) or, for those facilities without a resident council, a Resident Petition in Support of Proposed Use of Funds (Attachment 2). Originals must be maintained on file at the facility.
 - EQUAL 2020 – 2021 Proposed Spending Plan (Attachment 3).
- **Secton F:** To be completed and electronically submitted through the Health Commerce System.
 - **Section F: 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 2020-2021 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, in order to do business with New York State, you 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 in order to initiate a contract with the New York State Department of Health, 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 component of your application.

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 Award:

- **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).

Exhibit 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 the close of the award period (12 months from date of award).

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

SECTION E: Attachment 1

**New York State Department of Health
Division of Adult Care Facility/Assisted Living Surveillance
Application to Participate in the
Enhancing the Quality of Adult Living (EQUAL) 2020 - 2021**

**RESIDENT COUNCIL REPRESENTATIVE APPROVAL OF
PROPOSED EQUAL 2020-2021 SPENDING PLAN**

I, _____ (name of representative), have reviewed the uses of
_____ (name of facility), _____ (operating certificate #)

EQUAL 2020-2021 funds and agree that the proposed use of these funds is consistent with residents' priorities.

The top three preferences of the residents as determined by the residents include:

1. _____
2. _____
3. _____

Resident Council Representative

Date

SECTION E: Attachment 3

EQUAL 2020-2021 Proposed Spending Plan

A. Type of Funding Requested (Select All That Apply):

<input type="radio"/>	Capital Improvement Projects	Amount Requested:
	<i>These funds are used to enhance the physical environment of the facility and promote a higher quality of life for residents.</i>	

<input type="radio"/>	Local Assistance Projects	Amount Requested:
	<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 Request: _____

B. 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.

Budget Line Items	Capital Improvement Project Funds Requested	Local Assistance Project Funds Requested
Total Requested Per Funding Source		
Total Funding Requested		

EXHIBIT A

2020-2021 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:** _____

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 2019-2020 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 2019-2020 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