Division of Adult Care Facility and Assisted Living Surveillance

EQUAL: Enhancing the Quality of Adult Living

Purpose:
What is EQUAL?

What type of funding is EQUAL?

The EQUAL appropriation is comprised of two types of funding:

Local Assistance Funding – Local Assistance Projects will be available 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.

Capital Improvement Funding - Capital Improvement Project funds will be available to support the enhancement of the physical environment of the facility and promote a higher quality of life for residents.

What can EQUAL be used for?

Local Assistance	Capital Improvement
Clothing allowances	Air conditioning in resident areas
Computers and Televisions for resident use	Aesthetic facility upgrades
Improvements in food quality (featured menus or culinary events)	Outdoor leisure space (e.g., patios, community gardens, etc.)
Outdoor leisure projects	Enhancement or Expansion of Resident Areas
Staff training, outside of those that are regulatorily required (i.e., cultural or sensitivity training)	
Transportation for resident services/events	
Cultural, recreational or other leisure events.	

What would be inappropriate for EQUAL funding?

Legal or Regulatory Obligations CANNOT be funded with EQUAL awards
Regulatorily required staff training
Staff salaries
Bedroom furniture required pursuant to Regulation
EQUAL Funding CANNOT supplant the obligations of the facility Operator to provide a safe, comfortable living environment for residents in a good state of repair and sanitation
Creation or renovation of resident restricted spaces (i.e., staff offices)
Repaving broken walkways, replacing broken windows
Regular facility maintenance/repairs

How are EQUAL awards determined?

Facilities must submit ALL required components of the application in the manner and by the deadline provided.

Department staff review to determine:

1. Eligibility; and
2. The application is complete and timely.

A per person amount, based on eligible residents reported on 2nd Quarter QSIR. An additional allotment for facilities ≤100 beds.

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2021-2022 EQUAL Application Deadline, Components & Timeline

2021-2022 EQUAL Applications are due by 5:00 p.m. on November 19, 2021.

Required Components Include:

- **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 2021-2022 EQUAL Spending Plan, and certification of proper use of EQUAL funding. Confirmation of submission of necessary attachments is also required.

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Proposed Spending Plans are NOT a part of the 2021-2022 Application

2021-2022 EQUAL Anticipated Award Timeline:

1. Applications Due: 11/19/2021
2. DOH Review Complete: 11/26/2021
3. Payment List Approved: 11/30/2021
4. Intent to Award Letters Issued: 12/1/2021
5. Non-Awardee Letters Issued: 12/1/2021
6. Proposed Spending Plans Due: 12/14/2021
7. Spending Plans Approved/Payments Made: 12/31/2021

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Spending Plan Submission

EQUAL 2021-2022 Proposed Spending Plan

To be submitted to equal@health.ny.gov no later than 30 calendar days from the date of a New York State Department of Health Award Letter.

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

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
Total Requested Per Funding Source		
Total Funding Requested		

○ **RESIDENT COUNCIL REPRESENTATIVE APPROVAL:** I, _____ (name of representative), have reviewed the Proposed EQUAL 2021-2022 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 residents' priorities.

○ **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 2021-2022 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:_____

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EQUAL Expenditures & Required Documentation

EXHIBIT A

2021-2022 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:

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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 Section C (a) of my EQUAL 2021-2022 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 2020-2021 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

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Thank you!

Questions may be referred to the EQUAL Program at equal@health.ny.gov