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 2018-2019

Conditions for Participation in the EQUAL 2018-2019 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 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 of Health.

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 2018-2019 calendar year. The facility will be required to submit a completed **Section J** 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 above is not an exhaustive list of allowable expenses. The Department of Health will review all proposals for the acceptable use of program funds with final approval residing with the Department of Health.

8. EQUAL payments should be expended within twelve months of receipt of your check on the intended use(s) as outlined in Section D of the application. **Prior approval by the Department is required for any changes to be made in the approved Expenditure Plan and must include documentation to support that the resident council or, in the absence of a residents' council, discussion with at least three residents of the facility took place as part of the decision-making.** 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 Health of a proposed revocation, suspension, limitation or denial of the operator's operating certificate; or proposed assessment of civil penalties; issuance of a Department of Health 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 of Health 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 of Health for audit purposes. Such records 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 of Health 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 of Health 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 of Health 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 of Health 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 of Health, 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 Health of third parties with regard to the applicant's character, competence, experience or other matters relevant to the proposal.

18. The Department of Health 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 of Health before a payment can be authorized. The Department of Health is not liable for any expenses incurred before a payment is issued by the Department of Health.

20. The facility submissions must include a signed attestation (Section E of the electronic application) that the proposed spending plan reflects the priorities of the residents of the facility and was approved by the resident council or, in the absence of a resident council, at least three residents of the facility. The resident chairperson or president must also sign the attestation form attached at the end of these instructions (see Section F of the application) verifying the approval of the spending plan. The attestation will include documentation of the top three priorities of facility residents. The facility must email the signed attestation form to equal@health.ny.gov at the time of their application and maintain the original signed attestation form on file at the facility.

21. The Department of Health 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 of Health 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 of Health 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 of Health shall prescribe.

24. The successful applicant will permit, and shall require its agents, contractors and employees to permit, duly authorized representatives of the Department of Health 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 of Health, repay such payment to the Department of Health and/or complete or correct the cited deficiency within the time period specified by the Department of Health.

26. The Applicant and the Department of Health agree that the Applicant is an independent entity and not an employee or agent of the Department of Health. The Applicant agrees to indemnify the Department of Health and the State of New York against any loss the Department Health or the State of New York may suffer when such losses result from claims of any person or organization (excepting the Department of Health 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:

- **Sections A – E:** (to be completed and electronically submitted through the Health Commerce System). Includes facility information, acceptance/declination to participate in the EQUAL Program, expenditure plan and required certification/attestation documents.

- **Section F:** Resident Council Representative Approval of Proposed Spending Plan (to be completed and emailed to equal@health.ny.gov with the signed original maintained on file at the facility).

- **Section G:** Payment and Expenditure Tracking Form (to be completed and maintained on file by the facility).

- **Section H:** Resident Petition in Support of Proposed Use of Funds (required for use by facilities without resident councils). Must be completed and maintained on file by the facility.

- **Section I:** EQUAL Program Certification Page (to be completed, certified and submitted by the facility upon expenditure of EQUAL funds).

- ***Section J:** EQUAL Expense Schedule (to be completed and submitted to the Department with a PDF copy of all applicable receipts. A completed Section I: EQUAL Program Certification Page is to accompany the documentation.

- **New York State Office of the State Comptroller Substitute Form W-9 (DOH version) Request for Taxpayer Identification Number & Certification** (to be completed by operators who do not have an established Statewide Financial System (SFS) account).

- ***Failure to submit the required and/or any requested documentation will deem the applicant ineligible for future funding opportunities.

***New for 2018-2019**

SECTION F

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) 2018-2019

RESIDENT COUNCIL REPRESENTATIVE APPROVAL OF PROPOSED EQUAL 2018-2019 SPENDING PLAN

I, _____ (name of representative), have reviewed the uses of

_____ (name of facility), _____ (operating certificate #)

EQUAL 2018-2019 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 I

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 2018-2019 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 2018-2019 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

SECTION G

Facility Name: _____
Certificate Number: _____

New York State Department of Health
Division of Adult Care Facility/Assisted Living Surveillance
Enhancing the Quality of Adult Living (EQUAL) Program 2018-2019
Payment & Expenditure Tracking Form

DATE	TRANSACTION DESCRIPTION	VENDOR NAME	AMOUNT OF EQUAL FUNDS AWARDED	EXPENSE AMOUNT	BALANCE
	EQUAL 2018-2019 Award Payment	**N/A**	$		
			$	$	$

SECTION H

RESIDENT PETITION IN SUPPORT OF PROPOSED USE OF FUNDS
ADULT CARE FACILITY - ENHANCING THE QUALITY OF ADULT LIVING (EQUAL 2018-2019)

REQUIRED FOR ADULT CARE FACILITES WITHOUT RESIDENT COUNCILS

FACILITY NAME_____CERTIFICATE #_____DATE SUBMITTED_____

DESCRIPTION OF EQUAL 2018-2019 SPENDING PROPOSAL THAT ARE CONSISTENT WITH RESIDENT'S PRIORITIES:

_____

_____

_____

_____

_____

_____
Name of Operator (Print) (Date)

_____
Signature of Operator (Title)

RESIDENT NAME (PRINT)		**SIGNATURE (**Attach additional sheets if necessary)
_____		_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION H (cont.)

RESIDENT PETITION IN SUPPORT – Page ____

RESIDENT NAME (PRINT)		**SIGNATURE**
_____		_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Expense Schedule for EQUAL Program Funds 2018-2019

EQUAL Amount: $

Report Year (YYYY)		**Directions: Complete this schedule listing all expenses for which you are claiming the payment. Each expense line item should be accompanied by a receipt. All the receipts must be properly identified by the attachment no. and must be equal to the amount in dollars.**		
Operating Certificate #				
Facility Name				
Facility Address				
City				
State				
Zip Code				
Facility Contact Number				
No.	**Description of Expense**	**Amount in $**	**Attachment No.**	**Expenditure Approved by DOH (Y/N)**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

SECTION J (cont.)

Expense Schedule for EQUAL Program Funds 2018-2019

EQUAL Amount: $

Report Year (YYYY)		**Directions: Complete this schedule listing all expenses for which you are claiming the payment. Each expense line item should be accompanied by a receipt. All the receipts must be properly identified by the attachment no. and must be equal to the amount in dollars.**		
Operating Certificate #				
Facility Name				
Facility Address				
City				
State				
Zip Code				
Facility Contact Number				
No.	**Description of Expense**	**Amount in $**	**Attachment No.**	**Expenditure Approved by DOH (Y/N)**
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
Total		**$ -**		
Equal Program Funds Received by the Facility				
Difference		**$ -**		

I declare that the information contained in this report is true and accurate and agree that receipt of funds under the EQUAL program is conditioned upon the adherence to the conditions of participation for such program as stated in the EQUAL application.

Administrator		
Print Name	**Signature**	**Date**