Attachment 1

EQUAL 2025-2026 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 require 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.

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: _____

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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
Total Requested Per Funding Source		
Total Funding Requested		

- **RESIDENT COUNCIL REPRESENTATIVE APPROVAL:** I, _____ (name of representative), have reviewed the Proposed EQUAL 2025-2026 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 2025-2026 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:_____

INCOMPLETE WITHOUT RESIDENT(S) SIGNATURE(S)