EQUAL MODIFICATION REQUEST FORM

For each requested modification below, include a justification as to why the residents and facility have decided not to/cannot expend the EQUAL funding as requested and how the proposed modification will enhance the quality of live and/or life experience of the eligible residents (add additional pages if needed).

Facility _____

Operating Certificate # _____

Facility Contact Name & Number _____ **EQUAL Program Year** _____

Budget Line Item*		EQUAL Approved Expenditures	Change +/-	Revised EQUAL Expenditures	Narrative Justification Provide as much detailed information as possible.
Capital Improvement Projects					
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
	Subtotal:	**$0.00**	**$0.00**	**$0.00**	
Local Assistance Projects					
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	
				$0.00	**Attach additional sheets as necessary**
	Subtotal:	**$0.00**	**$0.00**	**$0.00**	
GRAND TOTAL		**$0.00**	**$0.00**	**$0.00**	

*** Include all approved EQUAL Expenditures, even if you are not requesting a change to that budget item**

Authorized Facility Signature	Date
Resident Council Representative: I have reviewed the proposed budget modification above and agree that the proposed use of these funds is consistent with the priorities of SSI/SSP/SN and/or Medicaid (ALP) residents' priorities. Resident Council Representative Signature:	Date
Resident Petition in Support: We the undersigned have reviewed the proposed budget modification above and agree that the proposed use of these funds is consistent with the priorities of the SSI/SSP/SN and Medicaid (ALP) residents' priorities. Resident Signatures:	Date
	Date
	Date
Authorized NYS DOH Signature	Date