

**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 2016-2017 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 2016-2017 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 \_\_\_\_\_

Adult Care Facility described herein and which executed the above instrument.

\_\_\_\_\_  
NOTARY PUBLIC My Commission Expires \_\_\_\_\_  
DATE