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