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## *Approved Entities*

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**Waiver Number**                    **545**

**Primary Entity Name**            **Angelic Childcare Services, LLC**

**Primary Address**                    *22 Youmans Drive*

**Primary Phone Number**            *(845) 538-6051*

*Spring Valley*

**Current Waiver Issued Beginning Period**

*NY*

*8/22/2016*

*10977-*

**Current Waiver Ending Period**

**County**

*Rockland*

*8/31/2019*

- |   |  |  |  |
|---|--|--|--|
| <input checked="" type="checkbox"/> LMSW                              | <input checked="" type="checkbox"/> CAT                                  | <input checked="" type="checkbox"/> Physical Therapy       | <input checked="" type="checkbox"/> Nursing (RN or Nurse Practitioner)           |
| <input checked="" type="checkbox"/> LCSW                              | <input checked="" type="checkbox"/> Psychology                           | <input checked="" type="checkbox"/> Occupational Therapy   | <input type="checkbox"/> Medicine (Physician, Physician Asst., Specialist Asst.) |
| <input checked="" type="checkbox"/> Licensed_Applied_Behavior_Analyst | <input checked="" type="checkbox"/> Certified_Behavior_Analyst_Assistant | <input checked="" type="checkbox"/> Audiology/Speech Lang. | <input checked="" type="checkbox"/> Mental Health Counseling                     |
| <input type="checkbox"/> Optometry                                    | <input type="checkbox"/> Other: <input type="text"/>                     |  |  |

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***Additional Sites if any - with Certificate Number***

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**Certificate Number**

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