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Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 502701044
Report Date: 05/05/2021
Date Signed: 05/05/2021 01:13:13 PM

Document Has Been Signed on 05/05/2021 01:13 PM **- It Cannot Be Edited**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 744 P STREET, MS 8-3-91 SACRAMENTO, CA 95814

FACILITY NAME:	ANGEL'S CARING HAND			FACILITY NUMBER:	502701044
ADMINISTRATOR:	ANTONIO, MA TABITHA			FACILITY TYPE:	740
ADDRESS:	3709 COYE OAK DR			TELEPHONE:	(209) 312-9880
CITY:	MODESTO	STATE:	CA	ZIP CODE:	95355
CAPACITY:	6	CENSUS:		DATE:	05/05/2021
TYPE OF VISIT:	Office	ANNOUNCED		TIME BEGAN:	01:00 PM
MET WITH:	ANTONIO, MA TABITHA Applicant/administrator			TIME COMPLETED:	01:30 PM

NARRATIVE

Facility Type: RCFE
Application Type: INITIAL
Capacity: 6
Census (if any clients in care): NO

Method: Telephone call with CAB
COMP II Participants: ANTONIO, MA TABITHA Applicant/administrator
Applicant/administrator participated in COMP II via telephone call with the analyst at CAB. During COMP II, applicant and administrator confirmed the understanding of Title 22. Component II was successfully completed.

During COMP II, CAB analyst confirmed Applicant/Administrator's understanding of following areas:
1.*Facility operation: License type, client/resident populations, and program*
2.*Staff qualifications and responsibilities*
3.*Applicant and Administrator qualifications*
4.*Program policy: Abuse, admission agreement, medication management, reporting incidents to CCL, restricted & prohibited conditions*
5.*Grievances, Complaints, Community resources*
6.*Physical plant, food service*
7.*Application document review and technical assistance: Criminal record clearance,*

Health screening, Fire clearance, First Aid/CPR certificate, Administrator certificate, Financial verification, Pre-licensing inspection, Compliance history, Control of property

8. Discussed the COVID-19 Mitigation Plan & PIN emailed

NAME OF LICENSING PROGRAM MANAGER: Jude De La Concepcion
NAME OF LICENSING PROGRAM ANALYST: Maria Ejaz
LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 05/05/2021

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 05/05/2021

This report must be available at Child Care and Group Home facilities for public review for 3 years.