



**ENHANCED CARE
MANAGEMENT (ECM)
AND
COMMUNITY SUPPORT
SERVICES (CSS)
BI-MONTHLY MEETING**



May 14, 2026

Meeting Agenda

Topics	Facilitator
Introductions	Provider Services
Community Connection and Member Engagement	Mike Shook
Point of Care Services	
Medicare Advantage DSNP – Eligibility and Coverage	Tapinder Dhillon
TOC Policy Updates	Andea Smith
Reporting Update	Niyati Reddy
CalAIM Claims Update CalAIM Screening Tools ECM/CS Contract Changes Protocol	Niyati Reddy
Closing / Open Forum	All





PROVIDER SERVICES

Bethany Evans



Friendly Reminders

Inform your HPSJ provider representative when you have a new employee start. Your provider representative will coordinate and schedule any necessary trainings.





CALAIM UPDATES

Niyati Reddy, Director of Special Projects, Operations



ECM Claims Reminder

- Providers must bill with applicable HCPCS codes that were published by DHCS and must adhere to the coding options defined and cannot add your own codes and modifiers
- To receive the Per Enrollee Per Month (PEPM) case rate, member must have an approved authorization AND you must submit a claim each month inclusive of units serviced that entire month
- Units of service are not specified in the ECM DHCS guidance, however, you must bill service units for every member encounter for the month
 - **1 unit = 15-min increments**
 - Example: if you see Member A for 1 hour on 5/14, that will equate to 4 units
 - Example: if you see Member A again for 30 minutes on 5/16, that will equate to 2 units
- DHCS monitors utilization and it's important to bill the correct number of units (services) provided to members per month or per claim line.
- Reminder: ECM Outreach is different from the above; ECM Outreach is before a member enrolls or the member never successfully enrolls
 - Outreach has a different set of HCPCS code and will be reimbursed at a specified rate per contract



Adding Additional CS Service or ECM

- Due to Health Plan's robust CalAIM Provider Network, HPSJ-MVHP has added a Screening Attestation process for any brand new and **existing** Providers that want to ADD an additional CS service OR a CS Provider that wants to ADD ECM to their scope of services
- Please contact the ContractingDepartment@hpsj.com for more information on the Screening Process
- The Screening Tool evaluates:
 - Whether there is a need for an additional provider in this service area
 - Whether you are currently seeing members within this scope of service
 - Provider Capacity and sustainability
 - Medi-Cal enrollment status
 - Partnerships within the Community
 - Documented policies/procedures and ready to submit to HPSJ
 - Member engagement process
 - Claims submission
 - Care planning system and tools
- The completed tool is vetted by a CalAIM Screening Committee and if approved, the tool and documentation will be forwarded for Readiness Review
- Tips: must have P&P ready to be submitted; TAT of 2 weeks once you request a screening tool;





ECM/CS REPORTING UPDATE

Niyati Reddy

Director, Special Projects Operations



ECM/CS Report Changes

- Per the Closed Loop Referral DHCS requirements, **beginning May 2026**, one (1) report will be due **monthly** instead of quarterly
 - ECM and CS Provider Return Transmission File
- The remaining set of ECM and CS reports will continue to be due **quarterly**
 - ECM Provider Initial Outreach Tracker File
 - ECM Potential Member Referral File
 - ECM Quarterly Capacity Report
 - CS Quarterly Capacity Report



ECM/CS Report Changes Con't

- The three (3) new **Closed Loop Referral (CLR) fields** on the Provider Return Transmission Files, which were previously optional, will be **required beginning with the May 2026 submission**.
 - **Referral Status:** Captures the status of the Member Referral as of the Date of Referral Status Update
 - **Date of Referral Status:** Captures the date associated with the Referral Status update
 - **Reason for Referral Loop Closure:** Required if Referral Status is 'Denied' or 'Referral Loop Closed' to provide additional detail on the outcome of the referral and a Member's engagement in services
- Drop-down options are included on the report template to select

Referral Status
1.Accepted
2.Declined (by Service Provider)
3.Pending
4.Outreach Initiated
5.Referral Loop Closed

Date of Referral Status (mm/dd/yyyy)
Date

Reason for Referral Loop Closure
1.Services Received
2.Service Provider Declined
3.Unable to Reach Member
4.Member No Longer Eligible for Services
5.Member No Longer Needs Services or Declines Services
6.Other



Updated Templates

- Templates were updated to reflect the updated submission frequency and the required CLR fields
- Email was sent from Provider Services (mtran@hpsj.com) on 4/30/2026 with updated templates attached
- Updated templates are also posted on File Exchange
- Please begin using the updated templates **beginning with the May 2026 submission** to avoid errors when uploading to File Exchange

File Exchange

Help ▾

Inbox

Program Files

User Program CalAIM ECM/CS Program : ×
Upload File

Inbox Outbox
Refresh

	FILE TYPE	FILE NAME	FILE SIZE	FILE STATUS	UPLOADED	UPLOADED BY	SELECT ALL			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>			
★	CS Provider Return Transmission Template	HPSJ CS Provider Return Transmission.xlsx	19 KB	Downloaded	05-01-2026 09:16:48 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡
★	CS Quarterly Capacity Template	HPSJ CS Quarterly Capacity.xlsx	19 KB	Uploaded	05-01-2026 09:16:29 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡
★	ECM Potential Member Referral Template	HPSJ ECM Potential Member Referral.xlsx	16 KB	Uploaded	05-01-2026 09:16:09 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡
★	ECM Provider Initial Outreach Tracker Template	HPSJ ECM Provider Initial Outreach Tracker.xlsx	21 KB	Uploaded	05-01-2026 09:15:35 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡
★	ECM Provider Return Transmission Template	HPSJ ECM Provider Return Transmission.xlsx	20 KB	Downloaded	05-01-2026 09:15:17 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡
★	ECM Quarterly Capacity Template	HPSJ ECM Quarterly Capacity.xlsx	21 KB	Uploaded	05-01-2026 09:14:53 AM	RFreschi	<input type="checkbox"/>	↓	↑	≡



ECM and CS Updated Reporting Requirements

File Name	Updated Frequency	Transmission
ECM Provider Return Transmission File	<p>Quarterly by 15th of the month following quarter end</p> <p>Monthly by 15th of the month following month end (Beginning May 2026 submission)</p>	Inbound from ECM Provider to Health Plan
ECM Provider Initial Outreach Tracker File	Quarterly by 15 th of the month following quarter end	Inbound from ECM Provider to Health Plan
ECM Potential Member Referral File	Quarterly by 15 th of the month following quarter end	Inbound from ECM Provider to Health Plan
ECM Quarterly Capacity Report	Quarterly by 15 th of the month following quarter end	Inbound from ECM Provider to Health Plan
CS Provider Return Transmission File	<p>Quarterly by 15th of the month following quarter end</p> <p>Monthly by 15th of the month following month end (Beginning May 2026 submission)</p>	Inbound from CS Provider to Health Plan
CS Quarterly Capacity Report	Quarterly by 15 th of the month following quarter end	Inbound from CS Provider to Health Plan



ECM and CS Report Due Dates

Reporting Period	File Name	Due Date
Q1 2026 (January – March 2026)	ECM Provider Return Transmission File ECM Provider Initial Outreach Tracker File ECM Potential Member Referral File ECM Quarterly Capacity Report CS Provider Return Transmission File CS Quarterly Capacity Report	Due April 15, 2026
April 2026	ECM Provider Return Transmission File CS Provider Return Transmission File	Due May 15, 2026
May 2026	ECM Provider Return Transmission File CS Provider Return Transmission File	Due June 15, 2026
June 2026	ECM Provider Return Transmission File CS Provider Return Transmission File	Due July 15, 2026
Q2 2026 (April – June 2026)	ECM Provider Initial Outreach Tracker File ECM Potential Member Referral File ECM Quarterly Capacity Report CS Quarterly Capacity Report	Due July 15, 2026



Friendly Reminders

- **Transitional Rent** fields were added on CS reports - **begin reporting with Q1 2026 data**
- Include all counties you serve [San Joaquin, Stanislaus, El Dorado, or Alpine]
- Provide capacity counts for **all community supports you offer**, based on your contract with Health Plan
- Total provider capacity count reported must be **equal or greater than** the total number of members currently served
- **Complete all four (4) ECM Reports and/or two (2) CS Reports**, even if you did not provide services to any of our members





TRANSITIONAL CARE

Andrea Smith, Manager Transition of Care



Birthing Care Pathway



- » Comprehensive **policy and care model roadmap** that will cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum.
- » Roadmap includes a series of **policy solutions that address members' physical, behavioral, and health-related social needs.**
- » Goals include **reducing maternal morbidity and mortality** and **addressing significant racial and ethnic disparities.**



What's changed?

DHCS has re-stratified the birthing population from all pregnant and postpartum (*12 months from end of pregnancy*) individuals being **High-risk** for TCS to:

High-Intensity Pregnancy and Postpartum TCS	Moderate-Intensity Pregnancy and Postpartum TCS
Any pregnant or postpartum member who meets any one of the criteria for high-intensity TCS outlined in section F.5.a. "Identification of Members for High- vs. Moderate Intensity Pregnancy and Postpartum TCS".	Any pregnant or postpartum member who does not meet the criteria for the high-intensity TCS outlined in section F.5.a. "Identification of Members for High- vs. Moderate Intensity Pregnancy and Postpartum TCS".



High-Intensity Pregnant & Postpartum (P&PP) TCS

Beginning of High-Intensity TCS:

- As soon as it's determined member meets high-intensity criteria **OR** no later than the beginning of the 3rd trimester (whichever is sooner)

Length of TCS:

- **Admissions/re-admissions for delivery or other end of pregnancy:**
 - When all the member's needs are met and no sooner than 60 days following the end of pregnancy
- **Admissions/re-admissions for any other reason:**
 - When all the member's needs are met and no sooner than 30 days post discharge

ECM Provider Role:

- Engage with ECM connected members throughout this period and ensure care coordination/completion of birthing checklist
- Provide a **single email address** for notification of member transitions
 - Respond to these emails as soon as possible and confirm member enrollment

Health Plan Role:

- Refer qualifying members in this population to ECM
- Communicate ECM connected member transitions to ECM provider
- Remain available to support ECM providers in completion of required TCS activities



TCS Birthing Supports Checklist

MCPs and their contracted entities must ensure completion of the **TCS Birthing Supports Checklist** for **all** pregnant and postpartum members, regardless of whether they meet criteria for high- or moderate- intensity categories

Box C: TCS Birthing Supports Coordination Checklist (Pregnant – Postpartum Period)

The care manager or care coordination entity must ensure referral and/or warm hand off of the following services if the member has needs, meets eligibility for referral, and aligns with their preferences*:

Medical Supports:

- » Postpartum visit according to ACOG/USPSTF Guidelines
 - Validated Behavioral Health Screenings
 - [IPV Screening](#) Using Evidence-Based Tool
 - Reproductive Life Planning
- » Pediatric visits according to AAP Bright Futures schedule through 2-month well-child visit
- » Any other follow-up visits recommended by a provider (e.g., specialty provider) or included in the discharge summary and/or instructions
- » Primary Care Provider visit scheduled (if no visit scheduled within the past 1 year)

Whole Person Needs:

Food, Nutrition Education, and Breastfeeding Supports

- » WIC
- » CalFresh
- » Lactation Services

MCP Benefits

- » Transportation Services
- » Doula Services
- » Appointment Assistance
- » Breast Pumps
- » ECM^{***}
- » Community Supports^{***}
- » CHW Services

Family Support Services

- » Paid Family Leave
- » Home Visiting[^]
- » Parenting Resources[‡]

Box C: TCS Birthing Supports Coordination Checklist Cont. (Pregnant – Postpartum Period)

Whole Person Needs Cont.:

Infant Support

- » Health Insurance for Infants
- » WIC (including infant formula)

Behavioral Health Needs

- » Behavioral Health Supports (e.g., Non-Specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC))
- » Dyadic Services

**This includes access to culturally and linguistically aligned services and supports, consistent with Medi-Cal policy.*

[^]Home Visiting services include (but are not limited to) CDPH California Home Visiting Program (CHVP), CDSS CalWORKs Home Visiting, American Indian Maternal Support Services (AIMSS), and county First 5s, as applicable

*^{***}DHCS' Closed Loop Referral (CLR) policy requires MCPs to close the loop for ECM and Community Supports services.*

[‡]Parenting resources include (but are not limited to) Home Visiting services, MCP educational information, First 5, and Black Infant Health.



Key Points

- Changes in TCS structure for **all** pregnant and post partum (P&PP) members:
 - TCS begins sooner and exists independent of inpatient/ED admissions
 - TCS lasts longer (no less than 60 days)
- **All** P&PP members must have **3** key milestones completed on delivery/end of pregnancy:
 - Completion of the postpartum visit with a medical provider (*follow ACOG: recommendation*)
 - Completion of the two-month well-child visit
 - Completion of all recommended follow-up listed in the discharge summary and/or instructions
- **All** P&PP members must have a completed birthing support checklist



- **CALAIM POPULATION HEALTH MANAGEMENT (PHM) POLICY GUIDE:**
[HTTPS://WWW.DHCS.CA.GOV/CALAIM/DOCUMENTS/PHM-POLICY-GUIDE.PDF](https://www.dhcs.ca.gov/CALAIM/DOCUMENTS/PHM-POLICY-GUIDE.PDF)
 - TCS considerations begin on pg. 47 of the January 2026 Guide
- **HPSJ SPECIFIC CONTACTS:**
 - Andrea Smith, Manager Transition of Care: asmith@hpsj.com
 - General TOC email: transitionofcare@hpsj.com





ENHANCED CARE MANAGEMENT (ECM) AND COMMUNITY SUPPORT SERVICES (CSS) UPDATE

Mike Shook, Director Care and Utilization Management



Referrals

ECM Member Enrollment

- Pursuit List
 - Overall, outreach to these members, measured by claims, is low
 - Overall, ECM Enrollment, measured by prior authorizations, is very low
 - What are the barriers to outreach and enrollment?
 - What are the outreach modalities being utilized – phone calls, texts, mail, boots on the ground, etc.
- Encourage all providers to develop relationships with network physicians, hospitals and county agencies to obtain referrals
- Understand all Community Supports (CS) that members are potentially eligible for given their ECM Population of Focus (PoF)
- Assess members enrolled in ECM for CS and make appropriate referrals



Referrals cont.

CS Member Enrollment

- Encourage all providers to develop relationships with network physicians, hospitals and county agencies to obtain referrals
- What are the barriers to outreach and enrollment?
- Understand ECM POFs the member may be eligible for
- Make referrals to the appropriate ECM provider



Enrollment

ECM Enrollment

- Per DHCS, ECM is broad but shallow and is developing tiered rates based on encounters
- ECM providers should:
 - See members face to face
 - Connect with member's PCP and CS provider(s)
 - Submit accurate and timely monthly claims

CS Enrollment

- Data shows CS does lower the cost of healthcare
- CS providers should:
 - See members face to face
 - Connect with member's ECM provider
 - Submit accurate and timely monthly claims



Homeless Patients

Homeless patients, or those at risk of becoming homeless, could benefit from the following:

- **Housing Navigation** – assistance in finding housing
- **Housing Deposits** – assistance in securing housing
- **Housing Tenancy** - Once housing is secured, the goal is to keep the patient in their housing
- **Short Term Post-Hospitalization Housing** and **Recuperative Care** are for those homeless members who do not have a place to recover once discharged from the hospital with clinical needs
- **Transitional Rent** – members may be eligible for 6 months of rent assistance
- **NOTE:** Service limit of 6 months (182 days) per rolling 12-month period (Recuperative Care, Post Hospitalization Short Term Housing and transitional rent. **

**** Transitional Rent may only have 6 months of rental assistance during the demonstration period (ends December 2029).**



Skill Development & Assistance

Are there patients who could use some assistance with improving self-help, social skills, or skills to be able to be successful in living in the environment they desire?

Day Habilitation programs may be the answer. These services can be provided in the patient's home or another location.

Some of your patients may need assistance with bathing, dressing, toileting, walking or feeding. Also, they may need assistance with making meals, grocery shopping or money management.

Personal Care and Homemaker Services are available to assist members.



Patients with Limitations

Some patients may have limitations due to illness or injury and may require special modifications, such as ramps and grab-bars to get into their home, patients in a wheelchair that may need doorways widened so they can independently get around in their home, stair lifts, or bathroom and shower changes to make it easier to bathe themselves.

Home Modifications are available to assist these patients.

These services do require an order from a doctor and the reasons why this patient needs such services/adaptations to their home. In addition, this will require a homeowner's consent to be signed prior to any changes made to the home.

Those who supply these services will assist with getting the order and homeowner consent, you do not need to worry.

If they are having problems obtaining these documents, Health Plan is here to help.



Help for Patients with Asthma

Patients with Asthma who have had several visits to the emergency department or admission to the hospital for asthma attacks could benefit from **Asthma Remediation** to better manage their Asthma!

Similar to home modifications, this service will identify asthma triggers in the patient's living environment and adaptations to the home may be made to remove them.

This also requires an order from a doctor and a homeowner consent.

As with home modifications, the Asthma Remediation provider will obtain the order and consents, and we are here to help if it is needed!



Patients with Chronic Conditions

Often times, patients with certain chronic conditions may be suffering from not getting enough of the right foods to eat to be healthy. These may be patients who have diabetes, heart disorder, heart failure, stroke, chronic lung disorders, HIV, Cancers and other conditions that impact the patient's nutrition.

Medically Tailored Meals/Medically supported Food are designed to help to help these individuals.

Please note these services are not for those who may not be able to get enough food due to their living circumstances, but for chronic conditions.



Sobering Centers

Sobering Centers are available for members who need to sober up, as long as they are not rowdy or causing problems. These are safe spaces for these patients to rest and sober up.

Also, these services do not require authorization, so please reach out to one of the providers who provide this service following the steps below.

Currently we have 1 provider in San Joaquin and 1 in Stanislaus Counties.

We are working diligently to find providers in Alpine and El Dorado counties to help these patients.



Family Help

Are there patients who have caregivers in their home that could use a break to take care themselves and keep them from burnout.

Respite services are intended to allow those caring for loved ones a break.



CS Services for ECM PoF

ECM PoF	Potential CS Services
<p>Adults Without Dependent Children / Youth Living with Them Experiencing Homelessness AND Families or Children and Youth Experiencing Homelessness</p>	<ul style="list-style-type: none"> • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Recuperative Care and Short-Term Post-Hospitalization Housing – to provide recovery focused housing • Medically Tailored Meals / Medically Supportive Food, Day Habilitation Programs or Sobering Centers – may address the needs of this PoF depending on individual circumstances
<p>Individuals at Risk for Avoidable Hospital ED Utilization AND Children and Youth at Risk for Avoidable ED or IP</p>	<ul style="list-style-type: none"> • Asthma Remediation • Medically Tailored Meals / Medically Supportive Food • Environmental Accessibility Adaptations (Home Modifications)
<p>Individuals with Serious Mental Health and / or SUD Need AND Children and Youth with SMI and / or SUD</p>	<ul style="list-style-type: none"> • Sobering Centers • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post-Hospitalization Housing • Medically Tailored Meals / Medically Supportive Food
<p>Adults Living in the Community and at Risk for LTC Institutionalization</p>	<ul style="list-style-type: none"> • Environmental Accessibility Adaptions (Home Modifications) • Respite Services • Personal Care and Homemaker Services • Medically Tailored Meals / Medically Supportive Food • Assisted Living Facility Transitions • Community or Home Transition Services



CS Services for ECM PoF cont.

ECM PoF	Potential CS Services
Adult Nursing Facility Residents Transitioning to the Community	<ul style="list-style-type: none"> • Assisted Living Facility Transitions • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post-Hospitalization Housing • Medically Tailored Meals / Medically Supportive Food
Children and Youth Enrolled in CSS or WCM	<ul style="list-style-type: none"> • Environmental Accessibility Adaptions (Home Modifications) • Respite Services • Personal Care and Homemaker Services • Medically Tailored Meals / Medically Supportive Food • Asthma Remediation
Children and Youth Involved in Child Welfare	<ul style="list-style-type: none"> • Day Habilitation Programs • Medically Tailored Meals / Medically Supportive Food • Environmental Accessibility Adaptions (Home Modifications) • Asthma Remediation
Youth Pregnancy and Postpartum	<ul style="list-style-type: none"> • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post-Hospitalization Housing • Medically Tailored Meals / Medically Supportive Food • Sobering Centers • Day Habilitation Program



CS Services for ECM PoF cont.

ECM PoF	Potential CS Services
Birth Equity	<ul style="list-style-type: none"> • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Short-Term Post-Hospitalization Housing • Medically Tailored Meals / Medically Supportive Food • Sobering Centers
Adults Transitioning from Incarceration AND Children / Youth Transitioning from a Youth Correctional Facility	<ul style="list-style-type: none"> • Transitional Rent • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services • Sobering Centers • Day Habilitation Programs





MEDICARE ADVANTAGE DSNP – ELIGIBILITY AND COVERAGE

Tapinder Dhillon, Manager Case Management



Medicare Advantage DSNP (Dual Special Needs Plan)

- ❑ HPSJ/MVHP launched a new Special Needs Plan (SNP) for Dual-Eligible (Medi-Cal & Medicare) members on **January 1st, 2026**.
- ❑ The new benefit program is called “HPSJ/MVHP Advantage D-SNP (HMO)”.



HPSJ/MVHP Advantage DSNP- CICM

- ❑ DHCS replaced the ECM (Enhanced care management) with CICM (California Integrated Care Management) for DSNP members.
- ❑ CICM program is provided by the HPSJ/MVHP case management team.
- ❑ Members enrolled in Advantage DSNP, do not qualify for ECM benefit. Therefore, any member meeting the criteria for ECM will be enrolled in CICM program.

Note: If member is actively enrolled and engaged in ECM and then enrolled into DSNP. The member can request continuity of care for ECM services by calling CS @ 888-361-7526.



Best Practices for ECM enrollment

- ❑ ECM provider must check the member eligibility and coverage before the outreach attempt to members to enroll in ECM

DRE

Search Patients

Patient Search

Member ID Current Members Only

Last Name

First Name [Multi-Patient Search](#)

Date of Birth M D Y

SSN/Case#/Medicaid#/CMR#

Note: A member who has not been assigned to a specific PCP as yet is designated as "PCP - Unselected" with provider ID 00000ZZ. This is no reflection of eligibility status. Please do not decline services based on this designation. Urge the member to call HPSJ Member Services Dept (209) 842-6320 to request a specific PCP assignment. (Note: PCP assignment requests must be made by the member.)

Member ID	Name	DOB	Sex	LOB	Copay				Elig
			Female	Medi-Cal	\$0	\$0/\$0	\$0/\$0	\$0	YES

Patient Demographics	
Membership ID	
Patient Name	
Address	
Phone	
Sex	
Date of Birth	
Age Today	
Language	
CIN Number	
Aid Code	
Medical Number	
Guardian ID	

- ❑ Do not enroll members in ECM, when member coverage is DSNP. Please call CM Care Coordinator phone # 800-822-6226 to connect member to HPSJ DSNP case management team.



Questions



Next Meeting

- July 9, 2026
- 8:30 am– 9:30am



THANK YOU!

Health Plan 
of San Joaquin

 Mountain Valley
Health Plan

www.hpsj-mvhp-org | 1-888-936-PLAN (7526)



San Joaquin

HPSJ/MVHP Headquarters
7751 South Manthey Road
French Camp, CA 95231



Stanislaus

1025 J Street
Modesto, CA 95354



El Dorado

4237 Golden Circle Drive
Placerville, CA 95667