



Rialto Unified School District Enrollment Checklist (TK - Kindergarten)

- Immunization Record
- *TB Test – must include results
- Proof of Date of Birth (birth certificate, certified birth record, baptismal certificate, passport, or affidavit)
- Current address verification in parent/guardian name (Utility bill, official mail, rental/lease agreement or payment receipts, property tax receipt, pay stubs, voter registration, or affidavit no more than 30 days old)
- Identification of the enrolling parent/guardian
- Dental Exam
- Physical Exam (recommended to meet 1st grade requirement, **required** for **ELO)
- Current/Signed** IEP if the student is receiving special education services

** Applies to all students (TK – 12th Grade) who seek admission to a California school for the first time or have been away from the U.S. for more than 12 months*

*** ELO – Extended Learning Opportunity. Extended day for TK students*

Enrollment Center



260 South Willow Avenue, Rialto, CA 92376

Phone: 909-873-4300 Fax: 909-873-4301

email: enrollmentcenter@rialtousd.org

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

STUDENT INFORMATION (please use blue or black ink)						OFFICE USE ONLY	
Legal Last Name		Legal First Name		Legal Middle Name			Notes: _____ Grade: _____ Date: _____ Student #: _____ School of Residence: _____ School Assigned: _____ Start Date: _____ Teacher/Counselor: _____ Classroom/AM or PM: _____ Birth Verification: _____ P.O.B: _____ Enter Code: _____ Reason: <input type="checkbox"/> Overflow <input type="checkbox"/> Inter/Intra <input type="checkbox"/> Other: _____ Address Verification: <input type="checkbox"/> Utility/Rent Receipt <input type="checkbox"/> Affidavit of Residence <input type="checkbox"/> Other: _____ <input type="checkbox"/> McKinney Vento <input type="checkbox"/> Foster 4-digit zip: _____ Enrolled by: _____
Grade	Retained? If yes, what grade?		Also Known As (other names used)				
Address		Apt./Space	Rialto <input type="checkbox"/> San Bernardino Fontana Colton <input type="checkbox"/> Other _____		Zip Code		
Mailing address, if different		Apt./Space	Rialto <input type="checkbox"/> San Bernardino Fontana Colton <input type="checkbox"/> Other _____		Zip Code		
Primary Phone Number		Date of Birth	Sex Male Female	Preferred Language of Correspondence			
Primary Email							
ETHNICITY (Please select one) Is your child Hispanic or Latino? Yes, Hispanic or Latino No, Not Hispanic or Latino		RACE (Please select all that apply) <input type="checkbox"/> American Indian or Alaska Native (Origins in North, Central or South America) <input type="checkbox"/> African American or Black <input type="checkbox"/> Cambodian Chinese <input type="checkbox"/> Filipino/Filipino American Guamanian <input type="checkbox"/> Hawaiian Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Vietnamese <input type="checkbox"/> White (Origins in Europe, North Africa, or the Middle East)					
FAMILY INFORMATION (If there is a custody/restraining order for your child, please provide copy)							
Name of Person Enrolling Student		Relationship to student <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caregiver <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian		Phone Number			
Name of Legal Mother		Lives with <input type="checkbox"/> Not in the home		Work Phone			
Name of Legal Father		Lives with <input type="checkbox"/> Not in the home		Phone Number			
				Work Phone			
CHILDREN LIVING UNDER YOUR CARE							
Name		Date of Birth		School			
Name		Date of Birth		School			
Name		Date of Birth		School			
PREVIOUS SCHOOL INFORMATION (List last school first)							
Name of School		City	State	Grade	School Year		
Name of School		City	State	Grade	School Year		
Has the student attended a Rialto USD school? Yes No (ex. Preschool)		If yes, name school:		Grade	School Year		
PARENT EDUCATION LEVEL			PRIOR SPECIAL EDUCATION PROGRAMS				
The California State Department of Education requests information regarding the highest level of education completed by the enrolling parent/guardian. Please check for both parents.			Please provide the following information for student placement in a special service or program:				
Mother/Guardian 1 Not a high school graduate High school graduate Some College College graduate <input type="checkbox"/> College degree from a 4 year university with additional coursework in graduate school			<input type="checkbox"/> My child has NOT participated in a special program <input type="checkbox"/> My child has had a special education evaluation				
Father/Guardian 2 Not a high school graduate High school graduate Some College College graduate College degree from a 4 year university with additional coursework in graduate school			My child has participated in the following services: <input type="checkbox"/> Specialized Academic Instruction (ex. RSP/SDC) <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Adaptive Physical Education <input type="checkbox"/> Physical Therapy Other: _____				

My signature certifies that all information provided is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within 24 hours for the safety of my student.

Parent/Guardian Signature: _____ **Date:** _____

Home Language Survey

Student Name: _____

Date of Birth: _____

Grade: _____

Directions to Parents and Guardians:

The California *Education Code* contains legal requirements which direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with these requirements. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If an error is made completing this home language survey, you may request correction before your student's English proficiency is assessed.

1. Which language did your child learn when they first began to talk? _____

2. Which language does your child most frequently speak at home? _____

3. Which language do you (the parents and guardians) most frequently use when speaking with your child? _____

4. Which language is most often spoken by adults in the home?
(parents, guardians, grandparents, or any other adults) _____

Please sign and date this form in the spaces provided below, then return this form to your child's teacher. Thank you for your cooperation.

Signature of Parent or Guardian: _____ Date: _____

OFFICE USE ONLY

School: _____ Reviewed by: _____
Enrollment Staff

Sent to Multilingual Programs on: _____

Received by MLP/LAC on: _____

Housing Questionnaire



The information provided below will help your child's school to determine whether you and/or your child may be eligible for specialized services and supports. This could include additional educational services through Title I, Part A and/or the federal McKinney-Vento Assistance Act. The information provided on this form will be kept confidential and only shared with appropriate school district and site staff.

Student Name	Date of Birth
School Assigned	Grade

Which of the following describes you and/or your family's current living situation? Please check all that apply.

- Sharing housing** with other(s) due to loss of housing, economic hardship, natural disaster, lack of adequate housing, or similar reason
- Staying in a **shelter** (family shelter, domestic violence shelter, youth shelter) or Federal Emergency Management Agency (FEMA) trailer
- Living in a car, park, campground, abandoned building, or other inadequate accommodations (i.e. lack of water, electricity, or heat)
- Temporarily living in a **motel or hotel** due to loss of housing, economic hardship, natural disaster, or similar reason
- I am a student under the age of 18 and **living apart from parent(s) or guardian**
- None of the above.** My student and I live in permanent, adequate housing

The undersigned parent/guardian certifies that the information provided above is correct and accurate.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Street Address	City	State Zip Code
		Phone Number

Your child or children may have the right to:

- Immediate enrollment in the school they last attended (school of origin) or the local school where you are currently staying, even if you do not have all the documents normally required at the time of enrollment.
- Continue to attend their school of origin, if requested by you and it is in the best interest.
- Receive transportation to and from their school of origin, the same special programs and services, if needed, as provided to all other children, including free meals and Title I.
- Receive the full protections and services provided under all federal and state laws, as it relates to homeless children, youth, and their families.

Please list all children currently living with you.

Name	Birthdate	Grade (if applicable)	School (if applicable)

If you have any questions about these rights, please contact your school site's homeless youth representative. If you have trouble contacting them, you may contact the Rialto USD McKinney-Vento & Foster Youth Liaisons at 909-873-4336.

Student Name: _____



Rialto Unified School District

Custody Issues

Parent Disputes over Custody in School Setting

Parents may try to use the school as a forum for disputing custody matters. If needed, the school district may consider including the following form in their annual notification to parent and legal guardians.

Custody disputes must be handled by the courts. The school has no legal jurisdiction to refuse a biological parent access to their child. The only exception is when a signed restraining order or proper divorce papers, specifically stating visitation limitations, are on file in the school office. Any student release situation which leaves the student's welfare in question will be handled at the discretion of the site administrator or designee. Should any such situation become a disruption to the school, law enforcement will be contacted and an officer requested to intervene. Unless Educational Rights have been revoked, both parents have access to student records.

Parents are asked to make every attempt not to involve school sites in custody matters.

The school will make every attempt to reach the custodial parent when a parent or any other person not listed on the emergency card attempts to pick up a child.

I have read and understand the above statement.

Parent/Guardian Signature 1

Date

Parent/Guardian Signature 2

Date

Office use only:

Date Received: _____

Home School: _____

Notification placed on Synergy: _____

Document(s) uploaded to Synergy: _____



RIALTO UNIFIED SCHOOL DISTRICT HEALTH SERVICES

815 S. Willow Ave., Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

STUDENT HEALTH HISTORY

Student Name: _____ Date of Birth: _____ Grade: _____

My child does **NOT** have any known health conditions

My child has the following health conditions:
(check all that apply **and** if medication or treatment is required at school)

**Medication / Treatment
REQUIRED at school**

<input type="checkbox"/> Allergies Type of allergy: _____ Type of Medication: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ADHD / ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Birth Defects / Genetic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blood / Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Kidney Disorder / Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Psychological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Serious accidents or hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer / Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Colostomy Bag	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 – Insulin Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable: <input type="checkbox"/> Dexcom <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Metformin <input type="checkbox"/> Humalog Insulin Pen	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Epilepsy / Seizures – <input type="checkbox"/> Requires Diastat	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Gastrostomy Tube (G-Tube) – <input type="checkbox"/> Requires G-Tube feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Heart Problems / Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tracheostomy <input type="checkbox"/> Requires Suctioning <input type="checkbox"/> Ventilator Dependent <input type="checkbox"/> Oxygen Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Special Treatments and/or Medications: _____

Parent/Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Emailed Health Services: _____ Verified by Health Services: _____ School: _____

Provided parent with the following documents:

Authorization for Medical Release Medication Form

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
_____ <i>Licensed Dental Professional Signature</i>		_____ <i>CA License Number</i>	_____ <i>Date</i>

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:
 Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other _____ None
 - I cannot afford a dental check-up for my child.
 - I do not want my child to receive a dental check-up.
- Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ► _____
Signature of parent or guardian
Date

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school **no later than May 31** of your child's first school year.
 Original to be kept in child's school record.

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last _____ First _____ Middle _____ BIRTH DATE—Month/Day/Year _____

ADDRESS—Number, Street _____ City _____ State _____ ZIP code _____ SCHOOL _____

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION
NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DtP/DtTd (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

Please check this box if you **do not** want the health examiner to fill out Part III.

Signature of parent or guardian _____ Date _____

Name, address, and telephone number of health examiner _____

Signature of health examiner _____ Date _____

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhcs.ca.gov/services/chdp

California Immunization Requirements for K–12th Grade (including transitional kindergarten)



Grade	Number of Doses Required of Each Immunization ^{1,2,3}				
K-12 Admission	4 Polio⁴	5 DTaP⁵	3 Hep B⁶	2 MMR⁷	2 Varicella
(7th-12th)⁸	K-12 doses	+ 1 Tdap			
7th Grade Advancement^{9,10}		1 Tdap⁸			2 Varicella¹⁰

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement. See fn. 8.) One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The varicella requirement for seventh grade advancement expires after June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

Instructions:

California schools are required to check immunization records for all new student admissions at TK / Kindergarten through 12th grade and all students advancing to 7th grade before entry. See shotsforschool.org for more information.

Unconditionally Admit a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil’s age or grade as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption.*

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil’s grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled “Exclude If Not Given By”), or
- A temporary medical exemption from some or all required immunizations.*

Conditional Admission Schedule for Grades K-12

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

Dose	Earliest Dose May Be Given	Exclude If Not Given By
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3¹	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4¹	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3²	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
Varicella #2	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday. If polio #3 is the final required dose, polio #3 should be given at least six months after polio #2.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after DTaP #2, and pupils should be excluded if not given by 12 months after second dose. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the seventh birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the requirement.

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

- review records of any pupil admitted conditionally to a school at least every 30 days from the date of admission,
- inform the parent or guardian of the remaining required vaccine doses until all required immunizations are received or an exemption is filed, and
- update the immunization information in the pupil's record.

For a pupil **transferring** from another school in the United States whose immunization record has not been received by the new school at the time of admission, the school may admit the child for up to 30 school days. If the immunization record has not been received at the end of this period, the school shall exclude the pupil until the parent or guardian provides documentation of compliance with the requirements.

* In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.



Enroll. Get Care. Renew.

Free or Low Cost Health Coverage
Exists for ALL Lower-Income
California Families (options on page 2)

CALIFORNIA
Information for other
states is different.



Renew Your Coverage in 2023-24!

IMPORTANT for 2023 and 2024: CONTINUOUS MEDI-CAL COVERAGE PROTECTIONS END STARTING APRIL 2023.

Do you or a family member have Medi-Cal coverage? If so, you may need to take steps to keep it. You will need to renew your Medi-Cal at some point between April 2023 and May 2024. Annual renewals are usually due in the same month you first enrolled in Medi-Cal.

What to Do to Stay Covered:

- ▶ **Update your contact information.** Tell your county Medi-Cal office about any changes in your contact information (mailing address, phone number, email) so they can contact you with information about how to renew your coverage.
- ▶ **Check your mail.** When it is time to renew coverage, Medi-Cal will mail you a letter to let you know if you need to complete a renewal form or if your renewal can be completed automatically.
- ▶ **Complete your renewal form.** If you receive a renewal form, your coverage will not be renewed unless you complete it. Renewal forms will be sent in a **YELLOW ENVELOPE**. Fill out the form and answer any county follow up questions right away by phone, online, mail or in person to help avoid a gap in your coverage.



How to Renew your Medi-Cal Coverage and Report Changes:

- ▶ **Set up an account online.**
Visit: <https://benefitscal.com/> OR
- ▶ **Contact your county Medi-Cal office.**
To find your county Medi-Cal office, visit dhcs.ca.gov/COL or call (800) 541-5555.

What if You No Longer Qualify for Medi-Cal Coverage?

If your family income increased above Medi-Cal eligibility levels (see income chart on second page), you may qualify for discounted premiums through Covered California. If so, when your Medi-Cal coverage ends, Covered California will send you information about your automatic enrollment and what you need to do to activate it. Your Covered California coverage would begin when:

- ▶ You pay your premium, OR
- ▶ If you have no premium, when you accept the coverage online or by phone.

Often when family income increases, your child(ren) may still qualify for Medi-Cal even if adult family members no longer qualify. Continue to fill out and submit renewal information to keep your child(ren)'s free Medi-Cal coverage even if you may be enrolled in Covered California.

Enroll.

Ways to enroll in Medi-Cal and Covered California:

- 📞 **1(800) 300-1506**
- 🌐 **www.coveredca.com**
- 🚶 **In-person: dhcs.ca.gov/COL**
- ✉️ **Apply by mail:** Medi-Cal printable applications here: www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx
- 👤 **Find Help in Your Community:**
Scan the QR code below or go to: allinforhealth.org/HealthCoverageResources to locate help near you.

Get Care.

- ▶ Find a primary care doctor. Ask your health plan for help locating an available doctor near you.
- ▶ Schedule an annual checkup for you and your child(ren). Young children need frequent well-child visits within a year.
- ▶ Your health plan is required to help you make appointments and get interpretation services. Additionally, Medi-Cal is required to help you get free transportation to your appointments.
- ▶ Find a dentist. Visit SmileCalifornia.org to find a Medi-Cal dentist and a dental home near you.
- ▶ In Covered California, dental care is covered for children. Adults will need to purchase an additional dental plan.

Renew.

DHCS Medi-Cal must be renewed every year except for those listed below. It is important to ensure that Medi-Cal has your current address so that when it's time to renew your coverage, they can contact you. If you receive a renewal notice, be sure to act! Children in foster care and former foster care youth are not required to renew their coverage. Postpartum individuals also do not need to renew their coverage within 12 months postpartum



Covered California health plans must be renewed every year. Renewal information will be mailed at the end of the year, or you can contact Covered California directly.

- ▶ **Scan the QR code** for information about when and how to renew!



Need Help?

Scan this QR code for
LOCAL HELP in your area.

OR GO TO:
www.allinforhealth.org

Options for Health Coverage

Medi-Cal:

- ▶ Children and adults qualify for full-scope Medi-Cal benefits depending on their income. Children, pregnant and postpartum individuals have higher income eligibility levels than other adults (see chart below).
- ▶ Medi-Cal covers ALL COSTS for screenings, immunizations, checkups, specialists, mental health, vision, dental services, and all other medically necessary care.
- ▶ Medi-Cal enrollment is available year round.
- ▶ Most Medi-Cal enrollees must enroll in a Medi-Cal health plan that will manage their health care coverage. Each health plan is different and has their own list of healthcare providers. Learn more about health plans at: <https://www.healthcareoptions.dhcs.ca.gov>
- ▶ Medi-Cal plans offer services using telehealth. Ask your provider about accessing care over video or phone.

- ▶ For more information about services covered under Medi-Cal for Kids & Teens, go to www.allinforhealth.org or click for the [DHCS webpage](#), flier for **kids** and **teens** and [know your rights letter](#).

Covered California:

- ▶ Covered California offers a selection of health plans. They help in comparing and choosing a health plan that works best for each person. To learn more, visit: CoveredCA.com
- ▶ Many Californians may qualify for financial assistance via a Premium Tax Credit or reductions in what enrollees pay for their health care (known as cost-sharing reductions).
- ▶ Enroll during Open Enrollment or any time you experience a **life-changing event**, like losing your job or having a baby. You have 60 days from the event to complete enrollment.



Immigrant Families

Expansion of Medi-Cal

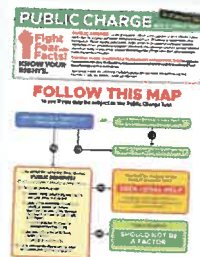
- ▶ Currently, every income-eligible child or person under the age of 26, every adult 50 years and older, DACA recipients, pregnant persons and recently pregnant persons are eligible for Medi-Cal health coverage and benefits **REGARDLESS OF IMMIGRATION STATUS**.
- ▶ Young people who are undocumented and turning 26 in 2023 will continue on Medi-Cal until 2024. By 2024, these individuals will be sent information about when and how to renew their Medi-Cal.
- ▶ In 2024, California is removing all barriers to Medi-Cal based on immigration status. Beginning on January 1, 2024, all California residents with qualifying incomes will be eligible for full Medi-Cal benefits regardless of their immigration status.

assistance. Some counties offer other health care options regardless of immigration status

Updated Public Charge Rule

- ▶ In December 2022, the federal government updated the public charge rule and made clear that using Medi-Cal is not considered for purposes of public charge (except in the case of long-term institutionalized care, also known as skilled nursing home care).
- ▶ Your child's enrollment in Medi-Cal and use of health care services will not impact your immigration status.

- ▶ While the public charge test may make you nervous, use this **Public Charge Roadmap** to better understand whether it applies to you or your family member.



Go to: allinforhealth.org/public-charge

Covered California

- ▶ Those with immigration documentation can qualify for Covered California and its financial

Financial Help. You or your family may qualify for free Medi-Cal or premium assistance under Covered California.*

SEE NOTE BELOW FOR INCOMES IN THIS RANGE	Covered California Premium Subsidies**										Tax credit continues beyond 400%
	American Indian / Alaska Native (AI/AN) Zero Cost Sharing					AI/AN Limited Cost Sharing					
% FPL	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%	
Household Size	If 2023 household income is at or less than										
1	\$13,590	\$18,755	\$20,385	\$27,180	\$28,947	\$33,975	\$36,150	\$40,770	\$43,760	\$54,360	
2	\$18,310	\$25,268	\$27,465	\$36,620	\$39,001	\$45,775	\$48,705	\$54,930	\$58,959	\$73,240	
3	\$23,030	\$31,782	\$34,545	\$46,060	\$49,054	\$57,575	\$61,260	\$69,090	\$74,157	\$92,120	
4	\$27,750	\$38,295	\$41,625	\$55,500	\$59,108	\$69,375	\$73,815	\$83,250	\$89,355	\$111,000	
5	\$32,470	\$44,809	\$48,705	\$64,940	\$69,162	\$81,175	\$86,371	\$97,410	\$104,554	\$129,880	
6	\$37,190	\$51,323	\$55,785	\$74,380	\$79,215	\$92,975	\$98,926	\$111,570	\$119,752	\$148,760	
	Medi-Cal for Adults		Medi-Cal for Pregnant & Postpartum Individuals			Medi-Cal Access for Pregnant & Postpartum Individuals					
	Medi-Cal for Kids (0-18 Yrs.)					CCHIP***					

* For information on calculating income and household size visit: healthcare.gov/income-and-household-information
 ** For Covered California, these 2023 income eligibility levels are effective at the beginning of the upcoming open enrollment period starting in November 1, 2023.
 *** For San Francisco, San Mateo, and Santa Clara County residents only.
 Note: Consumers after 138% FPL may qualify for a Covered California health plan with financial help including: federal premium tax credit, Zero Cost Sharing and Limited Cost Sharing AI/AN plans. Source: www.coveredca.com/pdfs/FPL-chart.pdf



OUR PARTNERS:



CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE



FOR MORE INFORMATION GO TO: www.allinforhealth.org

RIALTO UNIFIED SCHOOL DISTRICT • HEALTH SERVICES • 815 S. WILLOW AVENUE, RIALTO, CA 92376 • TEL: (909) 820-8150

Possible Referrals: If you have a personal health care provider, please feel free to use them. *We do not endorse any specific health care provider.*

Posibles referencias: Si tiene un proveedor de atención médica personal, no dude en utilizarlo. *No respaldamos a ningún proveedor de atención médica específico.*
For additional information, please scan the QR codes provided. • Para obtener información adicional, escanee los códigos QR proporcionados.

DENTAL CARE

DENTI-CAL

(800) 322-6384

LOMA LINDA SCHOOL OF DENTISTRY

(Pediatric Dental Clinic)

Loma Linda (909) 558-4689

SAN BERNARDINO HEALTH CENTER

(For Dental Services)

606 E. Mill St., San Bernardino
(800) 722-4777

ONTARIO HEALTH CENTER

(For Dental Services)

150 E. Holt Blvd., Ontario
(909) 458-9447

INLAND FAMILY COMMUNITY HEALTH CENTER

(For Dental Services)

665 North 'D' St., San Bernardino
(909) 708-8168

GOLDEN WEST DENTISTRY

9922 Sierra Ave., Fontana
(909) 822-4800

B R DENTAL

(Next to Clinica Medica Familiar)

436 S. Riverside Ave., Rialto
(909) 874-5200

DR. DAVID A. NEWSHAM, DDS

1735 N. Riverside Ave., Rialto
(909) 820-9081



MEDICAL CARE

SAC HEALTH SYSTEM

815 S. Willow Ave., Rialto

To schedule an appointment
(909) 382-7100

SAN BERNARDINO HEALTH CENTER

(For Medical Services)

606 E. Mill St., San Bernardino
(800) 722-4777

ONTARIO HEALTH CENTER

(For Medical Services)

150 E. Holt Blvd., Ontario
(909) 458-9447

BLOOMINGTON COMMUNITY HEALTH CENTER

18601 Valley Blvd., Bloomington

(909) 546-7520

MOMMY AND ME MEDICAL GROUP

790 E. Foothill Blvd., Rialto

(909) 421-0493

ARROWHEAD FAMILY HEALTH CENTER

16888 Baseline Ave., Fontana

(855) 422-8029

INLAND FAMILY COMMUNITY HEALTH CENTER

(For Medical Services)

665 North 'D' St., San Bernardino
(909) 708-8158



MEDICAL CARE...continued

LASALLE MEDICAL ASSOCIATES

790 E. Foothill Blvd., Rialto
(909) 546-7135

UNICARE COMMUNITY HEALTH CENTER

17500 Foothill Blvd. #A-2, Fontana
(909) 428-0170



VISION EXAMS

NORTHPOINTE OPTOMETRIC CENTER

1850 N. Riverside Ave., Ste. 220
Rialto (909) 875-1144

RIALTO OPTOMETRIC CENTER

1850 N. Riverside Ave., Ste. 210
Rialto (909) 421-3030

COLTON OPTOMETRIC CENTER

190 W. H St., Ste. 105
Colton (909) 825-9044



COUNSELING SERVICES

MESA COUNSELING SERVICES

850 E. Foothill Blvd.
Rialto (909) 421-9358

SOUTH COAST COMMUNITY SERVICES

1461 E. Cooley Dr., Ste. 100, Colton
(877) 527-7227



COVERED CALIFORNIA

(800) 300-1506

www.coveredca.com



IEHP

(800) 720-4347

www.iehp.org



MEDI-CAL

(800) 410-8829

keepmedicalcoverage.org



BENEFITS CAL

(877) 410-8829

www.benefitscal.com



SAN BERNARDINO COUNTY -

TRANSITIONAL ASSISTANCE DEPARTMENT

1175 W. Foothill Blvd., Rialto (877) 410-8829

