Rialto Unified School District
Enrollment Checklist
(1st Grade)

- ❑ Immunization Record
- ❑ *Tuberculosis (TB) Risk Assessment or TB Test with results

  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
- ❑ 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
- ❑ Physical Exam (recommended)
- ❑ **Current/Signed** IEP if the student is receiving special education services

Enrollment Center

260 S Willow Ave, Rialto, CA 92376

Tel: 909-873-4300 | Fax: 909-873-4301

enrollmentcenter@rialtousd.org

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM

STUDENT INFORMATION (please use blue or black ink)

Legal Last Name	Legal First Name	Legal Middle Name

Grade	Retained? If yes, what grade?	Also Known As (other names used)

Address	Apt./Space	Rialto San Bernardino Fontana Colton Other _____	Zip Code

Mailing address, if different	Apt./Space	Rialto San Bernardino Fontana Colton 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)
American Indian or Alaska Native (Origins in North, Central or South America)
African American or Black Cambodian Chinese Filipino/Filipino American Guamanian
Hawaiian Hmong Japanese Korean Laotian Other Asian Other Pacific Islander
Samoan Tahitian Vietnamese 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** Mother Father Caregiver Foster Parent Legal Guardian	Phone Number / Work Phone
Name of Legal Mother	Lives with / Not in the home	Phone Number / Work Phone
Name of Legal Father	Lives with / 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

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.

Mother/Guardian 1
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

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

PRIOR SPECIAL EDUCATION PROGRAMS

Please provide the following information for student placement in a special service or program:

My child has **NOT** participated in a special program
My child has had a special education evaluation

My child has participated in the following services:
Specialized Academic Instruction (ex. RSP/SDC)
Speech Therapy
Occupational Therapy
Adaptive Physical Education
Physical Therapy
Other: _____

OFFICE USE ONLY

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:
□ Overflow
□ Inter/Intra
□ Other: _____

Address Verification:
□ Utility/Rent Receipt
□ Affidavit of Residence
□ Other: _____
□ McKinney Vento
□ Foster
4-digit zip: _____

Enrolled by:

_____

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

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

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	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/DT/Td (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

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ 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)*

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.

☐ 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 Polio[4]	5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+ 1 Tdap			
7th Grade Advancement[9,10]		1 Tdap[8]			2 Varicella[10]

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 #3[1]	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	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.

Questions?

See the California Immunization Handbook at ShotsForSchool.org

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 dfferent.

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.

all in HEALTH CARE FOR ALL FAMILIES

A PROJECT OF The Children's Partnership

Need Help?

Scan this QR code for LOCAL HELP in your area.

OR GO TO:
www.allinforhealth.org

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 **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!

Options for Health Coverage

Medi-Cal:

- Children and adults qualify for full-scope Medi-Cal benefits depending on their income. Children, pregnant and post-partum 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

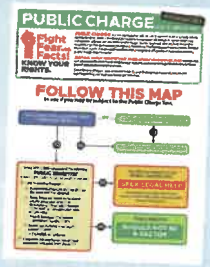
- Currently, every income-eligible child or person under the age of 26, every adult 50 years and older, DACA recipients, pregnant persons and recently pregnant persons are eligible for Medi-Cal health coverage and benefits **REGARDLESS OF IMMIGRATION STATUS.**
- Young people who are undocumented and 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.

Covered California

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

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*

all in HEALTH CARE FOR ALL FAMILIES
A PROJECT OF The Children's Partnership

OUR PARTNERS:
CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Metro LA
para los niños for the children

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

BENEFITSCAL
(877) 410-8829
www.benefitscal.com

SAN BERNARDINO COUNTY - TRANSITIONAL ASSISTANCE DEPARTMENT
1175 W. Foothill Blvd., Rialto (877) 410-8829

Updated: 01/2024