



Rialto Unified School District Enrollment Checklist (6th – 12th 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
- ☐ Transcripts/Check out grades from previous school
- ☐ **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)						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		<input type="checkbox"/> Rialto <input type="checkbox"/> San Bernardino <input type="checkbox"/> Colton <input type="checkbox"/> Fontana <input type="checkbox"/> Other: _____		Zip Code			
Mailing address, if different		Apt./Space		<input type="checkbox"/> Rialto <input type="checkbox"/> San Bernardino <input type="checkbox"/> Colton <input type="checkbox"/> Fontana <input type="checkbox"/> Other: _____		Zip Code			
Primary Phone Number		Date of Birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred Language of Correspondence			
ETHNICITY (Please select one) Is your child Hispanic or Latino? <input type="checkbox"/> Yes, Hispanic or Latino <input type="checkbox"/> 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) Name of enrolled or principal tribe(s): _____ <input type="checkbox"/> African American or Black <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino/Filipino American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> 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		Home Phone					
Name of Legal Mother		<input type="checkbox"/> Lives with <input type="checkbox"/> Not in the home		Work Phone					
				Home Phone					
Name of Legal Father		<input type="checkbox"/> Lives with <input type="checkbox"/> Not in the home		Work Phone					
				Home Phone					
Work Phone									
CHILDREN LIVING IN THE HOME									
Name		Date of Birth		School					
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?		If yes, name school:		Grade		School Year			
<input type="checkbox"/> Yes <input type="checkbox"/> No (ex: Preschool)									
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. Mother/Guardian 1 <input type="checkbox"/> Not a high school graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Some College <input type="checkbox"/> College graduate <input type="checkbox"/> College degree from a 4 year university with additional coursework in graduate school Father/Guardian 2 <input type="checkbox"/> Not a high school graduate <input type="checkbox"/> High school graduate <input type="checkbox"/> Some College <input type="checkbox"/> College graduate <input type="checkbox"/> College degree from a 4 year university with additional coursework in graduate school				Please provide the following information for student placement in a special service or program: <input type="checkbox"/> My child has NOT participated in a special program <input type="checkbox"/> My child has had a special education evaluation 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 <input type="checkbox"/> 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

Child Welfare & Attendance

260 S. Willow Ave.

Rialto, CA 92376

909-873-4336

EXPULSION AFFIDAVIT – GRADES SIX THROUGH TWELVE

In keeping with California State Education Code 48915 and 48918, Rialto Unified School District must be informed at the time of enrollment if the student is currently under an expulsion order from any other school district in or out of the State of California.

Students who have completed an assigned expulsion order or are currently under an expulsion order must be referred to the District's Child Welfare and Attendance office for placement*.

Falsification of this document will result in the student being dropped/withdrawn from the Rialto Unified School District.

(Student's Name)

(Birth Date)

Please check one:

Student is currently residing with: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Parent ☐ Caregiver
☐ Self (unaccompanied youth)

Please check one:

☐ Student is **NOT** under an expulsion order from any district.

☐ Student is currently under an expulsion order from:

(Name of School)

(City/State)

☐ Student is pending an expulsion from:

(Name of School)

(City/State)

Please check one:

Is there a Probation Officer assigned to your child? ☐ Yes ☐ No

If "Yes": Probation Officer Name: _____

Phone Number: _____

(Parent Name, please print)

(Parent Signature)

(Date)

OFFICE USE ONLY

Notified CWA: _____

Verified by CWA: _____

School: _____



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"/> Non-food Allergy	Type of allergy: _____ Type of Medication: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Food Allergy	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	<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"/> 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 checked="" 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

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.*

Enroll. Get Care. Renew.

FREE MEDI-CAL OR LOW-COST COVERED CALIFORNIA EXISTS FOR MOST LOW-INCOME CALIFORNIA FAMILIES.

- ▶ **Medi-Cal** is a public health insurance available to low-income Californians. Starting January 1, 2024, all income-eligible Californians qualify for full scope Medi-Cal benefits REGARDLESS OF AGE OR IMMIGRATION STATUS. Full scope Medi-Cal covers more than just care when you have an emergency. It provides medical, dental, mental health, and vision (eye) care. Applying for Medi-Cal via the Covered California website is the fastest way to get covered.
- ▶ **Covered California** is a free service for individuals and families to get free or low-cost health insurance OR to get help paying for private health insurance. More information on page 2.

The 6 Step Roadmap to Medi-Cal



Check Your Eligibility

Medi-Cal eligibility is based primarily on your income and state residency.



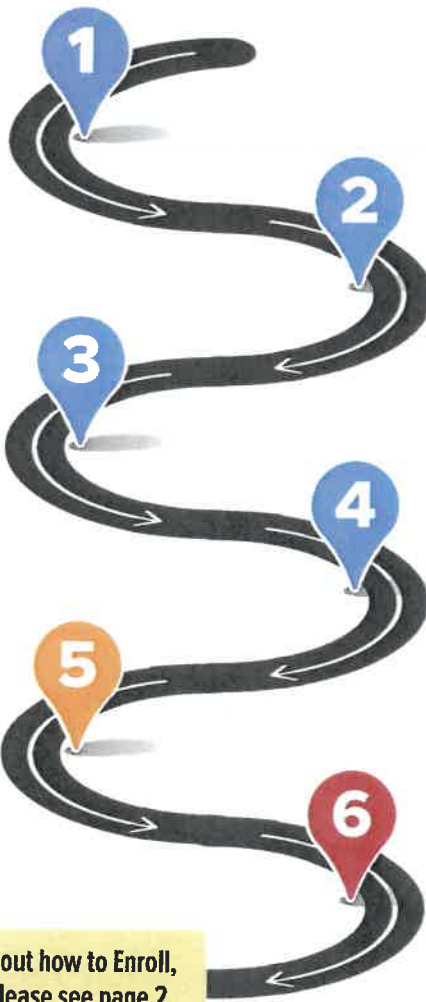
Eligibility Determination

The county will process your application for eligibility.



Get Care

Medi-Cal covers ALL medically necessary care.



APPLY for Medi-Cal or Covered California:



By phone: 1(800) 300-1506



www.CoveredCA.com (Covered CA and Medi-Cal)
www.BenefitsCal.com (Medi-Cal)



In-person: <https://bit.ly/3Tk3cXV>



Apply by mail: Medi-Cal printable applications here: <http://bit.ly/3RRENK>

Need Help?

Find Help in Your Community and More!
Scan this QR code.

www.allinforhealth.org



Apply for Medi-Cal



Medi-Cal enrollment is open and available all year. Read more about enrollment above!

Select a Health Care Plan



Most Medi-Cal enrollees must enroll in a health care plan.

Renew Your Medi-Cal



Most people must renew their Medi-Cal every year.



For more detailed information about how to Enroll, Get Care, and Renew Medi-Cal, please see page 2.



A PROJECT OF
TheChildren'sPartnership



This flyer was created with the support of the Whole Child Equity Partnership.



The 6 Steps to Medi-Cal

STEP 1

Check Your Eligibility

Children, pregnant and 12 months postpartum individuals have higher income eligibility levels than other adults. Your child(ren) may still qualify for Medi-Cal even if adult family members do not qualify.

If your income is above the Medi-Cal eligibility level, you may qualify for Covered California. If so, Medi-Cal will forward your information to Covered California, which will send you information about your automatic enrollment and what you need to do to activate it. [See the income limit chart.](#)

STEP 2

Enroll.

Apply for Medi-Cal in person, online, by mail, by phone, or find help in your community. Go to page 1 for more information or enroll at: www.CoveredCA.com

STEP 3

Eligibility Determination

After you apply:

- ▶ You will receive a **Notification of Likely Eligibility** by mail. **NEW!**—many Medi-Cal eligible applicants can now receive real time enrollment. This means that once the application is received, **you will have full coverage while the county processes the application.** For the fastest “real-time” enrollment, apply for Medi-Cal through www.CoveredCA.com (applications submitted by mail start accelerated enrollment when the county receives the application).
- ▶ You will receive a **Final Notice of Action** notifying you whether you can receive Medi-Cal. If you are denied Medi-Cal, you have the right to appeal. Ask for a **State Fair Hearing** by calling 800-952-5253, or by requesting it in writing.
- ▶ It can take up to 45 days to receive your Medi-Cal card in the mail after you apply, if you are eligible.

STEP 4

Select a Health Care Plan

You must choose a health plan within 30 days of receiving your health plan options in the mail. If you do not choose a plan within 30 days, Medi-Cal will choose a plan for you. The health plans available to you **depend on what county you live in.**



Go to the Medi-Cal [Managed Care Health Plan Directory](#) to find your options.



Visit the [Health Care Options](#) website for more information.

STEP 5

Get Care.

Find a primary care doctor. Ask your health plan for help locating an available doctor near you. Your health plan is required to help you make appointments, get interpretation services, **get free transportation to appointments**, and use telehealth.

Medi-Cal covers ALL COSTS for screenings, mental health, vision, dental services, and all other medically necessary care.

Find a dental home. Medi-Cal offers dental benefits to both children and adults. Visit SmileCalifornia.org to find a Medi-Cal dentist.

Kids and Teens. Medi-Cal for Kids & Teens provides free services to keep your child healthy from birth to age 21. For more information, visit: <https://bit.ly/3T1Ga8e>



2024 Financial Help

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

For information on calculating income and household size, visit:

www.allinforhealth.org/financial-help

STEP 6

Renew.

It's important to ensure that Medi-Cal has your current address and updated phone number so that when it's time to renew your coverage, they can contact you. If you receive a renewal notice, be sure to act!

Follow these steps:

- ▶ Set up a BenefitsCal.com account to get renewal updates.
- ▶ Submit changes to your contact information so Medi-Cal can contact you about renewals.
- ▶ Fill out and submit renewal forms when they are received (online, phone, mail, or in person).

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

Children in foster care and former foster youth are not required to renew their coverage. Postpartum individuals also do not need to renew their coverage within 12 months postpartum.



Covered California

If you are ineligible for Medi-Cal:

- ▶ 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: www.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).
- ▶ Open enrollment is the time of year when everyone can apply for a plan through Covered California. 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.

www.allinforhealth.org

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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

**E F P
T O Z
L P E T**



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

