



Rialto Unified School District Enrollment Checklist (Kinder & 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
- Dental Exam- only for Kinder
- Physical Exam (recommended for 1st grade)
- 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		
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		
Name of Legal Father		<input type="checkbox"/> Lives with <input type="checkbox"/> Not in the home		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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <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			<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 <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			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: _____			

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: _____

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**

<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

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)
Licensed Dental Professional Signature		CA License Number	Date

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 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/yyyy)
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/DTP/d (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)

RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

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.

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)

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.



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

- Requirements for K-12 admission also apply to transfer pupils.
- Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
- Any vaccine administered four or fewer days prior to the minimum required age is valid.
- Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday.
- 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.
- For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
- 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.
- For 7th-12th graders, at least one dose of pertussis-containing vaccine is required on or after the 7th birthday.
- For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
- 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.

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



The 6 Step Roadmap to Medi-Cal

1 Check Your Eligibility

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

2 Eligibility Determination

The county will process your application for eligibility.

3 Get Care

Medi-Cal covers ALL medically necessary care.

4 Apply for Medi-Cal

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

5 Select a Health Care Plan

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

6 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
The Children's Partnership



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

DR. DAVID A. NEWSHAM, DDS
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