RIALTO UNIFIED SCHOOL DISTRICT
District Enrollment Center
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301
Email: preschool@rialtousd.org

Preschool Enrollment Checklist

Qualification for State Preschool is based on income. Rialto U.S.D. offers preschool programs for those families who do not qualify based on their income. **Space is limited.

Please Provide the following documentation:

- ☐ Verification of income for each working parent in the home (income for the last 30 days
- ☐ CalWORKs/Cash Aid Assistance/CalFresh/Adoption or Foster Care Assistance (if applicable)
- ☐ Birth Records for ***ALL*** children under your care (to determine family size)
- ☐ Immunization Record
- ☐ Current Physical Exam dated within one year (form included in packet)
- ☐ T.B. Test with results or Risk Assessment dated within one year
- ☐ Photo I.D. of the enrolling parent/guardian
- ☐ Proof of Address dated within 30 days

Only Complete packets will be accepted

RIALTO UNIFIED SCHOOL DISTRICT ENROLLMENT FORM - PRESCHOOL

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 ☐ Colton ☐ Fontana ☐ Other: ______	Zip Code
Mailing address, if different	Apt./Space	☐ Rialto ☐ San Bernardino ☐ Colton ☐ Fontana ☐ Other: ______	Zip Code

Primary Phone Number	Date of Birth	Sex ☐ Male ☐ Female	Preferred Language of Correspondence

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)
Name of enrolled or principal tribe(s): ______________________
☐ African American or Black ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino/Filipino American
☐ Guamanian ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian (Laos) ☐ 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	Home Phone Work Phone
Name of Legal Mother	☐ Lives with ☐ Not in the home	Home Phone Work Phone
Name of Legal Father	☐ Lives with ☐ 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
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 an IEP, IFSP, ISP, or 504 Plan

My child receives the following services outside of Rialto USD:
☐ Specialized Academic Instruction (ex. RSP/SDC)
☐ Speech Therapy
☐ Occupational Therapy
☐ Adaptive Physical Education
☐ Physical Therapy
☐ Other: ______________________

Do you have any concerns about your child? ______________________

____

OFFICE USE ONLY

Notes:

____

Grade: ______________

Date: ______________

Student #: ______________

School of Residence: ______________

School Assigned: ______________

Start Date: ______________

Teacher: ______________

Classroom: AM or PM ______________

Birth Verification: _____

P.O.B: ______________

Enter Code: ______________

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

☐ RPAT ☐ SPED

Emailed: __________

Placement Received: ______________

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 <u>24 hours</u> for the safety of my student.

Parent/Guardian Signature: ______________________________ **Date:** ____________

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.

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Authorization to Release Information (Parent A)

I, ______________________________, parent of ______________________________ give authorization for
(Employee Name) (Student's Name)

Rialto Unified School District – Early Education, to verify all information utilized to determine my family's eligibility during the time I am enrolled in their program.

I authorize the sharing of information between agencies to verify my income, and eligibility. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support, training sites, schools, social service agencies, referring physicians, emergency shelters, and employers.

I declare under penalty of perjury that all information that I provided to Rialto USD – Early Education is true and correct, and that all documents submitted to Rialto USD – Early Education, are to the best of my knowledge true and correct. Failure to comply with these rules will result in termination from the Rialto USD – State Preschool Program.

______________________ ______________________ ______________
Employee/Parent Signature Employee ID # Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

Name of Employee Phone

Home Address City State Zip code

Name of Employer Contact Person

Employer/ Work Address City State Zip code

Employer Phone ______________________ Employer Email ______________________

Hire Date __________ Work Hours: Start__________ End__________ Job Title______________

Days of Employment: Sun______ Mon______ Tue______ Wed______ Thurs______ Fri______ Sat______

Pay Schedule: ❐ Weekly ❐ Bi-Weekly ❐ Twice a Month ❐ Monthly **Gross Salary (Per Pay Period) $**__________

Note if flexible schedule: Hourly Rate $________ Minimum hours per week______ Maximum hours per week______

I affirm that, to the best of my knowledge, the above information is true and correct:

SIGNATURE OF EMPLOYER DATE

OFFICE USE ONLY

Information obtained by:

- ☐ Telephone Phone No: ______________ Name: ______________________
- ☐ Facsimile Fax No: ______________ Name: ______________________
- ☐ E-Mai/ U.S.Mail ______________ Name: ______________________

Notes: ____

Date: ______________ Verified by: ______________________

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Authorization to Release Information (Parent B)

I, ______________________________, parent of ______________________________ give authorization for
(Employee Name) (Student's Name)

Rialto Unified School District – Early Education, to verify all information utilized to determine my family's eligibility during the time I am enrolled in their program.

I authorize the sharing of information between agencies to verify my income, and eligibility. Agencies that may be contacted include, but are not limited to, the Department of Public Social Services, Department of Child Support, training sites, schools, social service agencies, referring physicians, emergency shelters, and employers.

I declare under penalty of perjury that all information that I provided to Rialto USD – Early Education is true and correct, and that all documents submitted to Rialto USD – Early Education, are to the best of my knowledge true and correct. Failure to comply with these rules will result in termination from the Rialto USD – State Preschool Program.

______________________ ______________________ ______________
Employee/Parent Signature Employee ID # Date

EMPLOYMENT/ INCOME VERIFICATION

This is a State funded preschool program and therefore we must have confirmation of all income and work hours of parents whose children are enrolled in our program. Please release the following information for our records. All information is confidential, and used only for family eligibility purposes.

____
Name of Employee Phone

____
Home Address City State Zip code

____
Name of Employer Contact Person

____
Employer/ Work Address City State Zip code

Employer Phone ______________________ Employer Email ______________________

Hire Date __________ Work Hours: Start__________ End__________ Job Title______________

Days of Employment: Sun______ Mon______ Tue______ Wed______ Thurs______ Fri______ Sat______

Pay Schedule: ❒ Weekly ❒ Bi-Weekly ❒ Twice a Month ❒ Monthly **Gross Salary (Per Pay Period) $**__________

Note if flexible schedule: Hourly Rate $________ Minimum hours per week______ Maximum hours per week______

I affirm that, to the best of my knowledge, the above information is true and correct:

____
SIGNATURE OF EMPLOYER DATE

OFFICE USE ONLY

Information obtained by:

☐ Telephone Phone No: ______________ Name: ______________________
☐ Facsimile Fax No: ______________ Name: ______________________
☐ E-Mai/ U.S.Mail ______________ Name: ______________________

Notes: ____

Date: ______________ Verified by: ______________________

RIALTO UNIFIED SCHOOL DISTRICT
EARLY EDUCATION
260 South Willow Avenue, Rialto CA 92376
(909) 873-4300 Fax: (909) 873-4301

Self-Certification of Unemployed

I am currently:

- ☐ Seeking employment (Not receiving unemployment benefits)
- ☐ Stay at home Mom or Dad
- ☐ Full or Part time student
- ☐ Other (brief explanation):

____

____

____

____.

I, ____________________________________, swear under penalty of perjury, to the
(Parent Name)

best of my knowledge, that the information is true and correct.

____ _______________
Signature Date

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)

Condition	Medication / Treatment REQUIRED at school
☐ Non-food Allergy — Type of allergy: ____________ Type of Medication: ____________	☐ Yes ☐ No
☐ Food Allergy — 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

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

______________________ (NAME OF CHILD), born ______________ (BIRTH DATE) is being studied for readiness to enter

______________________ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : _____

a.m./p.m. to ______ a.m./p.m. , __________ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

______________________ (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) ______________ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Allergies: medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: ______________________

Address: ______________________

Telephone: ______________________

Date of Physical Exam: ______________

Date This Form Completed: ______________

Signature ______________________

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

Parents' Guide to Immunizations

Required for Pre-Kindergarten (Child Care)

Parents must show their child's Immunization Record as proof of immunizations (shots) before starting pre-kindergarten (child care) and at each age checkpoint after entry:

Age at Entry/checkpoint	Required Doses
2–3 Months	**1 Polio** **1 DTaP** **1 Hep B** **1 Hib**
4-5 Months	**2 Polio** **2 DTaP** **2 Hep B** **2 Hib**
6-14 Months	**2 Polio** **3 DTaP** **2 Hep B** **2 Hib**
15-17 Months	**3 Polio** **3 DTaP** **2 Hep B** **1 Hib*** (on or after 1st birthday) **1 Varicella** **1 MMR** (on or after 1st birthday)
18 Months–5 Years	**3 Polio** **4 DTaP** **3 Hep B** **1 Hib*** (on or after 1st birthday) **1 Varicella** **1 MMR** (on or after 1st birthday)

* One Hib dose must be given on or after the 1st birthday regardless of previous doses.
Required only for children younger than 5 years old.

DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine

Hep B = hepatitis B vaccine

Varicella = chickenpox vaccine

Hib = Haemophilus influenzae, type B vaccine

MMR = measles, mumps, and rubella vaccine

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.

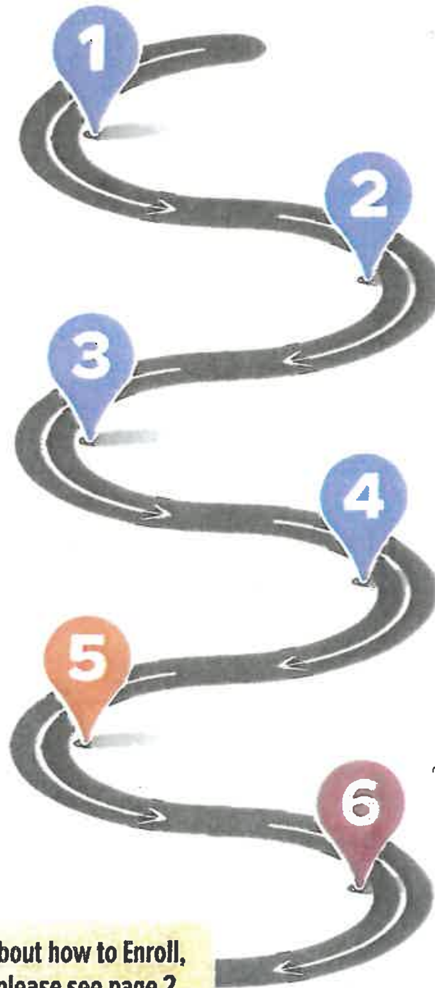
APPLY for Medi-Cal or Covered California:

- **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/3RRENIK***

Need Help?

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

The 6 Step Roadmap to Medi-Cal



Check Your Eligibility

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

Apply for Medi-Cal

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

Eligibility Determination

The county will process your application for eligibility.

Select a Health Care Plan

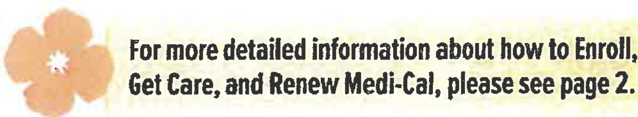
Most Medi-Cal enrollees must enroll in a health care plan.

Get Care

Medi-Cal covers ALL medically necessary care.

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.

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

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

COVERED CALIFORNIA
(800) 300-1506
www.coveredca.com

IEHP Inland Empire Health Plan

IEHP
(800) 720-4347
www.iehp.org

DHCS Medi-Cal

MEDI-CAL
(800) 410-8829
keepmedicalcoverage.org

BenefitsCal

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

SAN BERNARDINO COUNTY Transitional Assistance

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

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