



## CITY OF RIALTO CHILDCARE REIMBURSEMENT REQUEST

**Applications are processed on a first come, first served basis.  
Applications will be processed until all funding is allocated.**

In response to the harsh economic impact that COVID-19 has had on City of Rialto (City) residents, the Rialto Childcare Assistance Program was implemented to assist City residents with a one-time reimbursement of up to \$1,500 for childcare assistance. Reimbursements can be requested for childcare expenses incurred from March 3, 2021 to the present.

**Please type or use ink. Do not use pencil. Write legibly. Do not leave any blank spaces. All blank spaces must be completed. If a question does not apply, you still need to respond by writing "N/A" (not applicable) instead of leaving the space blank.**

**Submit a completed application with the required support documents to [rialtocares@rialtoca.gov](mailto:rialtocares@rialtoca.gov) or drop off the application at City Hall to the attention of Janet Franco, 150 S. Palm Ave, Rialto, CA 92376.**

### **CHECKLIST**

Please ensure that all the below items are included in your request. Requests submitted with incomplete information will not be processed.

**STEP ONE.** Determine your eligibility for the program (The following items in Step 1 must **All** be checked to establish eligibility:

- I am a Rialto resident
- The address of my primary residence is within a qualified census tract **OR** I am within the U.S. Department of Housing and Urban Development (HUD) established "Low- Income Limits". (Please reference the Qualified Census Tract Verification found on page 5 or the 2021 HUD Income Limits Table found on page 6).
- I currently do not receive any other forms of childcare assistance.

**STEP TWO.** Submit the following documents:

- Completed Childcare Reimbursement Request Application (This form)
- Dependent care provider receipt(s) and proof of payment **OR** Proof of Payment Affidavit if paid cash
- Copy of Government issued Photo Identification (I.D.) **AND** Utility Bill if I.D. does not have Rialto Address
- Qualified Census Tract Verification Form
- Completed W-9 Form (will be provided by staff if approved)
- Individual Provider Information Form (if applicable)
- Individual Provider Government issued Photo Identification (if applicable)



## CITY OF RIALTO CHILDCARE REIMBURSEMENT REQUEST APPLICATION

### 1. APPLICANT INFORMATION

DATE: \_\_\_\_\_

Applicant Name(s): \_\_\_\_\_

Address:

\_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

#### a. Dependent information

Please list every eligible child (dependent) in your household:

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### b. COVID-19 Impact

For the time-period of March 27, 2020 to the present, were you, or any member of your household, impacted by the COVID-19 pandemic?

Yes  No

### 2. PROVIDER CARE INFORMATION (complete for each dependent)

Name of Childcare Provider: \_\_\_\_\_

Name of dependent being cared for: \_\_\_\_\_

Address of Childcare Provider: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_



Name of Childcare Provider: \_\_\_\_\_

Name of Dependent being cared for: \_\_\_\_\_

Address of Childcare Provider: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

### 3. REIMBURSEMENT REQUEST AMOUNT

**Submit proof of payment for the amount of each reimbursement request.**

List the month, day, or week and the amount of the reimbursement request below:

<b>Month/Day/Week</b>	<b>Amount</b>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

**Total amount Requesting Reimbursement for: \$ \_\_\_\_\_**

**If requesting reimbursement for a private babysitter, please also complete the Individual Provider Information Form.**



## Acknowledgements and Signatures

I certify the information included in this application and the documentation provided is true and correct. I understand that the penalty for providing false information and/or failing to provide the required documentation shall result in the denial of my childcare reimbursement request. I acknowledge that I have not received another form of childcare assistance during the requested time period of reimbursement.

I further certify that the dependent(s) I am requesting reimbursement for have lived with me for more than one-half of the calendar year. I understand that the City reserves the right to request additional documentation to determine my eligibility for reimbursement.

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**Applicant Name**

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**Applicant Signature**

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**Date**

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**Applicant Name**

---

**Applicant Signature**

---

**Date**



## Qualified Census Tract Verification

To be eligible for childcare expense reimbursement assistance, the applicant must meet one of the following: (1) the Low Mod Area Benefit (LMA) criteria or (2) be income eligible. The applicant meets the LMA National Objective if, the applicant’s residence is located in an area where at least 51 percent of the residents are LMA persons.

Please complete all the information below. If you need additional guidance, please contact Avant Garde staff at (909) 816-2408 or (909) 816-2863.

### APPLICANT INFORMATION

Applicant name(s): \_\_\_\_\_

Applicant address: \_\_\_\_\_

Applicant phone number: \_\_\_\_\_

Dependent name(s): \_\_\_\_\_

\_\_\_\_\_

### DETERMINING CENSUS TRACT & BLOCK GROUP

To determine if your residence falls within an eligible census tract/block group, please complete the following steps.

1. Visit the website below:
  - <https://arcg.is/vPmrb>
2. Enter your residence address.
3. Click on the map where your address is located. Find the number under the “FIPS” section: the last 7 digits is your Census Block Group.

Example:

The screenshot shows a map of Rialto, California, with a blue arrow pointing to a pop-up window titled "USA Census BlockGroup Area". The window displays the following information:

FIPS	060710039001
COUNTY	San Bernardino
STATE	CA
POP2014	2,392
SQMI	0.28

A blue arrow points from the FIPS value "060710039001" to a blue box containing the value "0039001".



4. Please Check the corresponding census tract / block group number below.

- |                                  |                                  |                                  |                                  |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 0034032 | <input type="checkbox"/> 0035052 | <input type="checkbox"/> 0036071 | <input type="checkbox"/> 0039001 |
| <input type="checkbox"/> 0034041 | <input type="checkbox"/> 0035061 | <input type="checkbox"/> 0036091 | <input type="checkbox"/> 0039002 |
| <input type="checkbox"/> 0034052 | <input type="checkbox"/> 0035062 | <input type="checkbox"/> 0036093 | <input type="checkbox"/> 0040032 |
| <input type="checkbox"/> 0034053 | <input type="checkbox"/> 0035091 | <input type="checkbox"/> 0036122 | <input type="checkbox"/> 0040041 |
| <input type="checkbox"/> 0035051 | <input type="checkbox"/> 0035101 | <input type="checkbox"/> 0037001 | <input type="checkbox"/> 0043011 |
| <input type="checkbox"/> 0043023 | <input type="checkbox"/> 0035102 | <input type="checkbox"/> 0037002 |                                  |

My residential address is not in a census tract listed above. I understand that the City will contact me to complete the Supplemental Application Forms and submit financial documents to determine my income eligibility per the below U.S. Department of Housing and Urban Development 2021 Income Limits.

Maximum Annual Household Income Limits as Determined by HUD effective April 1, 2021								
Persons in Household								
	1	2	3	4	5	6	7	8
80% Moderate Income	\$44,250	\$50,600	\$56,900	\$63,200	\$68,300	\$73,350	\$78,400	\$83,450



**CITY OF RIALTO CHILDCARE REIMBURSEMENT REQUEST:  
INDIVIDUAL PROVIDER INFORMATION  
(Only complete if applicable)**

**Private Babysitter Information (complete for each babysitter, if requesting reimbursement for multiple providers)**

Name of Provider: \_\_\_\_\_

Name of dependent being cared for: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Social Security Number of Provider: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of dependent being cared for: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Social Security Number of Provider: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of dependent being cared for: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Social Security Number of Provider: \_\_\_\_\_

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**



**CITY OF RIALTO CHILDCARE REIMBURSEMENT REQUEST:  
PROOF OF PAYMENT AFFIDAVIT  
(Only complete if applicable)**

Name of Provider: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Name of Dependent: \_\_\_\_\_

I, \_\_\_\_\_, have received cash payment from \_\_\_\_\_  
(provider name) (applicant name)

in the amount of \$ \_\_\_\_\_, for childcare services provided for, \_\_\_\_\_.  
(dependent name)

The dates for the childcare services were \_\_\_\_\_.

The dates for payment were \_\_\_\_\_.

I certify the information included in this affidavit is true and correct. I understand that the penalty for providing false information will be the denial of the Applicant's childcare reimbursement request.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Name

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date