Riverside University HEALTH SYSTEM Behavioral Health

Attachment C

RIVERSIDE COUNTY INDIGENT SCREENING FORM/ADULT

1. CLIENT INFORMATION

Last Name_____ First Name_____ ____ Male ____ Female

Age:_____ Marital Status: _____

Current Address:

_____ How Long_____?

Street_____ City _____ State_____

Current Employer: _____ Job Title:_____

Approx. Salary $_____ per _____ Length of Time in Current Job: _____

2. INFORMATION REGARDING SPOUSE

Last Name_____ First Name_____

DOB _____ SSN_____

Address (Write "SAME" if same as patient): _____

Current Employer: _____ Job Title:_____

Approx. Salary $_____ per _____ Length of Time in Current Job: _____

3. RESIDENCY STATUS DETERMINED BY:

a. Reasoned intent as demonstrated by:
   i. Yes ☐ No ☐ Resided in Riverside County a minimum of 30 days.
   ii. Presence of support system in Riverside County.
b. Existence of a physical dwelling within Riverside County to which patient can return.
c. Patient receives public benefits within Riverside County.

4. Does the patient have any form of insurance which would provide payment for inpatient psychiatric services:
YES ☐ NO ☐
If Yes: name of insurance carrier_____

5. Is the patient receiving any other benefits or financial assistance (i.e. unemployment, disability, retirement accounts)? YES ☐ NO ☐
If yes, please explain: _____
_____

The above is stated on information and belief and I declare under penalty of perjury under the laws of the State of California that I believe it to be true.

_____ _____
Patient Signature Date

_____ _____
Hospital Rep Sign./Printed Name and Title Date

Rev Date: 1/9/19