Riverside University HEALTH SYSTEM Behavioral Health

Attachment D

RIVERSIDE COUNTY INDIGENT SCREENING FORM/CHILD

1. CLIENT INFORMATION

_____ Male

Last Name________________________ First Name________________________ _____ Female

Age:________ Marital Status: ___________________________

Current Address:

____ How Long__________?

Street____ City _______________ State_________

2. INFORMATION REGARDING MOTHER

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. INFORMATION REGARDING FATHER

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:_________

4. RESIDENCY STATUS DETERMINED BY:

a. Address of Parent of Guardian.

b. Yes ☐ No ☐ Resided in Riverside County a minimum of 30 days.

5. Does the patient have any form of insurance which would provide payment for inpatient psychiatric services?
YES ☐ NO ☐
Name of insurance carrier:____

6. Is either parent 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