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 or Guardian.

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

5. Does the patient have any form of insurance other 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