RIVERSIDE COUNTY INDIGENT SCREENING FORM/ADULT

1. CLIENT INFORMATION

___ Male

Last Name _____ First Name _____ ___ 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 (ie 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