

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