CHIP PATIENT SCREENING

1. TRANSACTION IDENTIFIER:

0 = ER, Not Admitted
1 = Hospital Inpatient
2 = Hospital Outpatient
3 = Community Clinic
4 = Private Physician
5 = Home Health Svs.
6 = Ambulance, SNF, or Other Sources

2. PATIENTS LAST NAME (Full Legal Name):

3. PATIENTS FIRST NAME:

4. SSN:

5. SEX: 1 = Male 2 = Female 0 = Unknown

6.ETHNICITY:

1 = White
2 = Black
3 = Hispanic
4 = Native American / Eskimo / Aleut
5 = Asian / Pacific Islander
6 = Other
0 = Unknown

7. FAMILY SIZE: 01 02 03 04 05 06 07 08 09 10
If more than 10 write in the number _____ 00 = Unknown

8. FAMILY MONTHLY INCOME:

1 = 0 - 499
2 = 500 - 999
3 = 1,000 - 1,499
4 = 1,500 - 1,999
5 = 2,000 - 2,499
6 = 2,500 - 2,999
7 = 3,000 - 3,499
8 = 3,500 - 3,999
9 = 4,000 +
0 = Unknown

9. INCOME SOURCE:

1 = Earned 2 = Disability 3 = Retirement
4 = Public Assistance 5 = Other/Unknown 0 = None

10. TYPE OF EMPLOYMENT:

1 = Executive / Professional 2 = Production / Labor 3 = Sales / Service
4 = Farming / Forestry 5 = Unemployed / Retired 0 = Unknown

11. PATIENT ZIP:

12. ZIP EXT.: 0000

13. ELA STATUS:

1 = Yes 2 = No 3 = Unknown 0 = N/A

14. OSHPD PROVIDER #: 000301279

I hereby certify the above information provided by me is true and accurate to the best of my knowledge.

Patient Signature **Date** **Facility Representative**

Inpatient Only **15. P/C DIAGNOSIS:**

16. PROCEDURE PERFORMED:

17. TYPE OF OUTPATIENT SERVICES:

01 = Primary Care
02 = Specialty Care
03 = Home Health Care
04 = Dental Care
05 = Laboratory
06 = Medical Supplies
07 = Optometry
08 = Pharmacy
09 = Podiatry
10 = Detoxification
11 = Radiology
12 = Ambulatory Surgery
13 = Other or Unknown
00 = Not Applicable, (ER or Inpatient)

18. TYPE OF EMERGENCY SERVICE:

1 = Non Emergency, Released
2 = Emergency, Released
3 = Non Emergency, Transferred Elsewhere
4 = Emergency, Transferred Elsewhere
5 = Non Emergency, Admitted to Hospital
6 = Emergency, Admitted to Hospital
0 = Not Applicable

19. AMOUNT PAID: $

20.PAYMENT SOURCE:

1 = Self Pay
2 = Private Insurance
3 = Medicare
4 = Medi-Cal 7 = 17000
5 = CHIP 8 = Other
6 = MISP 0 = Unknown

21. CREDIT INDICATOR:
Debit = Blank
Credit = CR

22. PROVIDER ZIP CODE: 92868

23. ZIP EXT.: 3297

24. CHDP: 1 = Yes 2 = No 0 = Unknown

Y2k Requirements:

25. DATE OF BIRTH: / /

26. DATE OF SERVICE (ADMIT)

27. DATE OF DISCHARGE (IP Only)

Liquid Assets :	Bank Name:	Checking Account # :	Balance: $	Savings Account #:	Balance: $

Credit Union Name:	Checking Account#:	Balance: $	Savings Account #:	Balance: $

Securities/stocks/bonds/cash: $	Credit Card (s): Bank Name:	Amount Owed: $	Limit: $:

Business Equipment: Total: $

Non Liquid Assets: Car/truck/other:	Market Value: $ $	Amount Owed: $ $	Net Value: $ $

Living Expenses: Housing/Rent (per month) $	Food $	Clothing: $	Utilities: $	Total: $

Other: (please describe) Amount Owed: $ Total: $

Description of Patient's Circumstances:

Patients Signature: Date: