

**ICAMA FORM 7.01
NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION**

DATE REQUESTED FOR MEDICAID OPENING	- -
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DATE OF MEDICAID CLOSURE	- -
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A. REFERRAL INFORMATION

FROM: Include: Name, Agency, Mailing Address, Telephone Number, Fax Number and E-mail Address

TO: Include: Name, Agency, Mailing Address, Telephone Number, Fax Number and E-mail Address

B. CHILD INFORMATION

1. NAME/BIRTHDATE/SOCIAL SECURITY NUMBER ETC.

Child A		Race*	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black /African American	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Unknown	
Legal Name <i>Must be the name associated with the SSN below</i>			Ethnicity*	<input type="checkbox"/> Hispanic/Latino <i>*Check if applicable</i>					
*Social Security # (SSN) <i>Required to open Medicaid case</i>				<i>*Check all boxes that are applicable</i>					
Birthdate - -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female								

Basis of Medicaid eligibility <i>(Check only one)</i>	Adoption Assistance		Guardianship Assistance Program
	<input type="checkbox"/> Title IV-E	<input type="checkbox"/> State-funded	<input type="checkbox"/> Title IV-E GAP

Child B		Race*	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black /African American	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Unknown	
Legal Name <i>Must be the name associated with the SSN below</i>			Ethnicity*	<input type="checkbox"/> Hispanic/Latino <i>*Check if applicable</i>					
*Social Security # (SSN) <i>Required to open Medicaid case</i>				<i>*Check all boxes that are applicable</i>					
Birthdate - -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female								

Basis of Medicaid eligibility <i>(Check only one)</i>	Adoption Assistance		Guardianship Assistance Program
	<input type="checkbox"/> Title IV-E	<input type="checkbox"/> State-funded	<input type="checkbox"/> Title IV-E GAP

Child C		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown					
Legal Name <i>Must be the name associated with the SSN below</i>		Race* <i>*Check all boxes that are applicable</i>					
*Social Security # (SSN) <i>Required to open Medicaid case</i>							
Birthdate - -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity* <input type="checkbox"/> Hispanic/Latino <i>*Check if applicable</i>					
Basis of Medicaid eligibility <i>(Check only one)</i>		<i>Adoption Assistance</i> <input type="checkbox"/> Title IV-E <input type="checkbox"/> State-funded			<i>Guardianship Assistance Program</i> <input type="checkbox"/> Title IV-E GAP		
2. ADOPTIVE PARENT(S)/GUARDIAN(S):							
Parent/Guardian 1- Name:							
Parent/Guardian 2- Name:							
3. ADDRESS IN NEW OR CURRENT RESIDENCE STATE:							
Number and Street:							
County: <i>(if known)</i>							
City:		State:		Zip: -			
Telephone : - - (ext)		E-mail :					
4. PREVIOUS ADDRESS (if applicable):							
Number and Street:							
County: <i>(if known)</i>							
City:		State:		Zip: -			
Telephone : - - (ext)		E-mail : <i>(If not the same as in Section 3 above)</i>					
5. CHILD IS NOT RESIDING WITH ADOPTIVE PARENT(S)/GUARDIAN(S): (Check one)							
<i>Case remains open and child remains eligible for Medicaid despite absence from adoptive home</i>							
<input type="checkbox"/> Inpatient residential treatment							
<input type="checkbox"/> School							
<input type="checkbox"/> Temporary absence from the home <i>(not for school or residential treatment)</i>							
<input type="checkbox"/> Other Please give brief explanation							
C. CERTIFICATION							
This is to certify that the records of my agency show the above named child(ren) to be eligible for the Medicaid Identification document(s) in his\her\their new residence state in accordance with the information contained herein and the attached Adoption Assistance Agreement or Guardianship Assistance Agreement.							
In addition, I hereby certify that the attached agreement(s) is/are a true copy/copies of the most current Adoption Assistance Agreement(s) or Guardianship Assistance Agreement(s) for the named child(ren) in the files of my agency and is/are in effect unless the residence state is notified that it/they has/have been terminated by my agency or state.							
Signed at:							
City		State					
This	day of	20					

<i>Signature:</i>			
Name	Telephone Number	-	- (ext)
Title	E-mail address		
Agency			

DISTRIBUTION:

*Original with copy of current Adoption Assistance/Guardianship agreement to (new) Residence State
 (1) copy to adoptive parent(s) (1) file copy retained in issuing office*

Prototype