

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

DATE REQUESTED FOR MEDICAID OPENING

- -

A. CHILD INFORMATION

1. NAME/BIRTHDATE/SOCIAL SECURITY NUMBER ETC.

Child A

Legal Name

*Social Security #

Required to open Medicaid case

Birthdate - -

Gender Male Female

Race*

American Indian/Alaskan Native
 Asian
 Black /African American
 Native Hawaiian/Other Pacific Islander
 White
 Unknown

**Check all boxes that are applicable*

Ethnicity*

Hispanic/Latino
**Check if applicable*

Basis of Medicaid eligibility Title IV-E State-funded Title IV-E GAP (Guardianship Assistance Program)

Child B

Legal Name

*Social Security #

Required to open Medicaid case

Birthdate - -

Gender Male Female

Race*

American Indian/Alaskan Native
 Asian
 Black /African American
 Native Hawaiian/Other Pacific Islander
 White
 Unknown

**Check all boxes that are applicable*

Ethnicity*

Hispanic/Latino
**Check if applicable*

Basis of Medicaid eligibility Title IV-E State-funded Title IV-E GAP (Guardianship Assistance Program)

Child C

Legal Name

*Social Security #

Required to open Medicaid case

Birthdate - -

Gender Male Female

Race*

American Indian/Alaskan Native
 Asian
 Black /African American
 Native Hawaiian/Other Pacific Islander
 White
 Unknown

**Check all boxes that are applicable*

Ethnicity*

Hispanic/Latino
**Check if applicable*

Basis of Medicaid eligibility Title IV-E State-funded Title IV-E GAP (Guardianship Assistance Program)

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:			
City:		State:	Zip: -
Telephone : - - (ext)		E-mail :	
4. PREVIOUS ADDRESS (if applicable):			
Number and Street:			
County:			
City:		State:	Zip: -
Telephone : - - (ext)		E-mail : <i>(If not the same as in Section 3 above)</i>	
5. IF CHILD IS NOT RESIDING WITH ADOPTIVE PARENT(s)/GUARDIAN(s) GIVE REASON:			
B. 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			
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*