**TODAY’S DATE: August 9, 2022**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Effective date for all updates: Click to enter date. | | | | | | | | |
| 1. **REFERRAL INFORMATION** | | | | | | | | |
| **FROM** | Name:  Title:  State Agency:  Telephone:  Email:  Note: Fax? Call for #: | | | Enter or paste your Contact information by clicking here. Field will expand as you enter text. | | | | |
| To search Contacts by state, visit: [ICAMA State Contacts-Full Information | AAICAMA](https://aaicama.org/icama-state-contacts-full-information/) | | | | | | | | |
| **TO** | Name:  Title:  State Agency:  Telephone:  Email:  Note: Fax? Call for #: | | | Enter or paste Contact information by clicking here. Field will expand as you enter text. | | | | |
| 1. **CHILD INFORMATION** | | | | | | | | |
| **CHILD 1** | | | | | | | | |
| Name: | | | | Click here to enter name. | | | | |
| Social Security Number: | | | | Click here to enter SSN. | | | | |
| Date of Birth (DOB): | | | | Click to enter DOB. | | | | |
| **Basis of Eligibility** | | | | Title IV-E Adoption Assistance  NON-Title IV-E Adoption Assistance  Title IV-E Guardianship Assistance Program | | | | |
| **CHILD 2** | | | | | | | | |
| Name: | | | | Click here to enter name. | | | | |
| Social Security Number: | | | | Click here to enter SSN. | | | | |
| Date of Birth (DOB): | | | | Click to enter DOB. | | | | |
| **Basis of Eligibility** | | | | Title IV-E Adoption Assistance  NON-Title IV-E Adoption Assistance  Title IV-E Guardianship Assistance Program | | | | |
| **CHILD 3** | | | | | | | | |
| Name: | | | | Click here to enter name. | | | | |
| Social Security Number: | | | | Click here to enter SSN. | | | | |
| Date of Birth (DOB): | | | | Click to enter DOB. | | | | |
| **Basis of Eligibility** | | | | Title IV-E Adoption Assistance  NON-Title IV-E Adoption Assistance  Title IV-E Guardianship Assistance Program | | | | |
| **CHILD 4** | | | | | | | | |
| Name: | | | | Click here to enter name. | | | | |
| Social Security Number: | | | | Click here to enter SSN. | | | | |
| Date of Birth (DOB): | | | | Click to enter DOB. | | | | |
| **Basis of Eligibility** | | | | Title IV-E Adoption Assistance  NON-Title IV-E Adoption Assistance  Title IV-E Guardianship Assistance Program | | | | |
| **CHILD 5** | | | | | | | | |
| Name: | | | | Click here to enter name. | | | | |
| Social Security Number: | | | | Click here to enter SSN. | | | | |
| Date of Birth (DOB): | | | | Click to enter DOB. | | | | |
| **Basis of Eligibility** | | | | Title IV-E Adoption Assistance  NON-Title IV-E Adoption Assistance  Title IV-E Guardianship Assistance Program | | | | |
| 1. **MEDICAID CASE OPENED WITH FORM 7.01** | | | | | | | | |
|  | | | | | Medicaid Case Number | | Click here to enter Case Number. | |
|  | | | | | Medicaid Case NOT Opened | | Reason: Click here to enter text. Field will expand with text. | |
| Status Update | | | | | | | | |
| **Reason** | | |  | | Extension expired or not granted | | | |
|  | | Family moved to new state | | | |
|  | | Child-only moved to new state | | | |
|  | | Parent or Guardian no longer legally responsible for child(ren) | | | |
|  | | Parent or Guardian determined to no longer provide *any s*upport for child(ren) | | | |
|  | | Parent or Guardian opts out of Medicaid / Alternate insurance used | | | |
|  | | Other: Click here to enter text. | | | |
| Information Update | | | | | | | | |
|  | | Name change: | | | Click here to enter text. | | | |
|  | | New or changed SSN: | | | Click here to enter new or changed SSN. | | \*Please call to discuss: | Click here to enter Contact phone number. |
|  | | Adoption/Guardianship finalized: | | | Date: Click to enter date. | | | |
|  | | Family moves within Residence State: | | | Click here to enter new Residence State address. | | | |
|  | | Family: New phone or email: | | | Click here to enter new phone and/or email. | | | |
|  | | Additional information: | | | Click here to enter text. | | | |
| **\*Notes:** Enter notes by clicking here. Field will expand as you enter text. | | | | | | | | |
| **D. ELIGIBILITY EXTENSION** | | | | | | | | |
| Eligibility for Assistance Extended: Eligibility is determined by Agreement State only. | | | | | | | | |
|  | | | Title IV-E Assistance eligibility extended through: | | | Click to enter date. | Medicaid MUST remain open for Title IV-E recipients. | |
|  | | | | | | | | |
|  | | | NON-Title IV-E Assistance eligibility extended through: | | | Click to enter date. | Medicaid MUST remain open for NON-Title IV-E recipients. | |
| **Notes:** Enter notes by clicking here. Field will expand as you enter text. | | | | | | | | |
|  | | | | | | | | |