**TODAY’S DATE: August 2, 2023**

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| **Date Requested for Medicaid Opening:** Click to enter date. |
| 1. **REFERRAL INFORMATION**
 |
|  **FROM** |  Name: Title: State Agency:Mailing Address:  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:Mailing Address:  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 here to enter DOB. |
| Gender: | Click here to enter text. |
| Race/Ethnicity: | Click here to choose an item. | If Other, please explain: Click here to enter text. |
| **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 here to enter DOB. |
| Gender: | Click here to enter text. |
| Race/Ethnicity: | Click here to choose an item. | If Other, please explain: Click here to enter text. |
| **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 here to enter DOB. |
| Gender: | Click here to enter text. |
| Race/Ethnicity: | Click here to choose an item. | If Other, please explain: Click here to enter text. |
| **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 here to enter DOB. |
| Gender: | Click here to enter text. |
| Race/Ethnicity: | Click here to choose an item. | If Other, please explain: Click here to enter text.  |
| **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 here to enter DOB. |
| Gender: | Click here to enter text. |
| Race/Ethnicity: | Click here to choose an item. | If Other, please explain: Click here to enter text. |
| **Basis of Eligibility** | [ ]  Title IV-E Adoption Assistance [ ]  NON-Title IV-E Adoption Assistance [ ]  Title IV-E Guardianship Assistance Program |
| 1. **PARENT, GUARDIAN, or \*OTHER**
 |
| Name: | Click here to enter name. | Category: | Click here to choose an item. |
| Name: |  Click here to enter name. | Category: | Click here to choose an item. |
| **NEW STATE ADDRESS (Mailing address)** |
| Telephone: | Click here to enter telephone. | Email: | Click here to enter email. |
| Street: | Click here to enter street address. | City: | Click here to enter city. |
| County: | Click here to enter county. | State: | Click to select state. | Zip: | Click to enter Zip. |
| **PREVIOUS STATE ADDRESS (Mailing address)** |
| Telephone: | Click here to enter telephone. | Email: | Click here to enter email. |
| Street: | Click here to enter street address. | City: | Click here to enter city. |
| County: | Click here to enter county. | State: | Click to select state.  | Zip: | Click to enter Zip.  |
| \*If Other, please explain: Click here to enter text. Field will expand as you enter text. |
|  **Notes:** Enter notes by clicking here. Field will expand as you enter text. |
| 1. **CERTIFICATION**
 |
| This is to certify that the records of my state agency show the above-named child(ren) to be eligible for Medicaid. As an ICAMA Member, your state is obligated to accept this ICAMA Form and the Adoption Assistance Agreement as complete verification of eligibility. No additional, individual, state information is required. *Note: Receipt of Medicaid cannot be delayed or denied due to state, administrative practices.* |
| **Signature of ICAMA Compact Administrator or Designee:****X**       *(Compact Administrator or Designee signature required. Type authorizing name-as-signature here.)* | Date: **August 2, 2023** |
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**Note:** The ICAMA processes Title IV-E Guardianship Agreements to support state administration of children’s permanency as a courtesy. Guardianship Agreements are not under the jurisdiction of the ICAMA.