

ICAMA FORM 6.01

NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

A. CHILD IDENTIFYING INFORMATION

1. NAME/BIRTHDATE/SOCIAL SECURITY NUMBER ETC:

(a) Child A's Name

Social Security #

Race*

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

*Check all boxes that are applicable

Birthdate: - -

Ethnicity*

Hispanic/Latino

*Check if applicable

Gender: Male Female

(b) Child B's Name:

Social Security #

Race*

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

*Check all boxes that are applicable

Birthdate: - -

Ethnicity*

Hispanic/Latino

*Check if applicable

Gender: Male Female

(c) Child C's Name:

Social Security #

Race*

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

*Check all boxes that are applicable

Birthdate: - -

Ethnicity*

Hispanic/Latino

*Check if applicable

Gender: Male Female

2. ADOPTIVE PARENTS:

Parent 1- Name:

Race*

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

*Check all boxes that are applicable

Ethnicity*

Hispanic/Latino

*Check if applicable

Parent 2- Name:

Race*

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

*Check if applicable

Ethnicity*

Hispanic/Latino

*Check if applicable

3. CURRENT FAMILY ADDRESS:

Number and Street:

County:

City: _____ State: _____ Zip _____ -

Telephone: : - - (ext _____)

4. FAMILY ADDRESS IN NEW RESIDENCE STATE:

Number and Street:

County:

City: _____ State: _____ Zip _____ -

Telephone: : - - (ext _____)

5. IF CHILD IS NOT RESIDING WITH ADOPTIVE PARENTS GIVE REASON:

6. BASIS OF MEDICAID ELIGIBILITY:

Child A: Title IV-E/SSI Title IV-E\AFDC State Funded Adoption Assistance/Medicaid Option

Child B: Title IV-E/SSI Title IV-E\AFDC State Funded Adoption Assistance/Medicaid Option

Child C: Title IV-E/SSI Title IV-E\AFDC State Funded Adoption Assistance/Medicaid Option

7. DATE OF MEDICAID CLOSURE: Last day of the month the child is living in the originating state

Child A: - -

Child B: - -

Child C: - -

8. DATE REQUESTED FOR MEDICAID OPENING: First day of the following month

Child A: - -

Child B: - -

Child C: - -

B. MEDICAID COVERAGE FOR STATE-FUNDED CHILDREN

1. THE ADOPTION ASSISTANCE STATE **DOES** **DOES NOT** provide Medicaid to children with state funded adoption assistance as an optional Medicaid group.

2. THE ADOPTION ASSISTANCE STATE **DOES** **DOES NOT** provide Medicaid to children receiving state funded adoption assistance from another ICAMA state if the child was eligible to receive adoption assistance.

C. OTHER MEDICAL COVERAGE

1. Does the child continue to be eligible for other medical assistance from the adoption assistance state?

Child A YES NO Child B YES NO Child C YES NO

2. Does the child have other third party coverage through any program, organization or person?

Child A: YES NO UNKNOWN

Child B: YES NO UNKNOWN

Child C: YES NO UNKNOWN

3. LIST SOURCES OF MEDICAL COVERAGE OR BENEFITS:

Child A: SSI SSA CHAMPUS PRIVATE INSURANCE

Child B: SSI SSA CHAMPUS PRIVATE INSURANCE

Child C: SSI SSA CHAMPUS PRIVATE INSURANCE

D. REFERRAL INFORMATION			
FROM: Compact Administrator's Name:			
Number and Street:			
County:	Telephone: - - (ext)		
City:	State:	Zip -	
TO: Compact Administrator's Name:			
Number and Street:			
County:			
City:	State:	Zip -	
State Status: Current residence state IS <input type="checkbox"/> IS NOT <input type="checkbox"/> the Adoption Assistance State			
E. CERTIFICATION			
<p>This is to certify that the records of my office 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, the attached Adoption Assistance Agreement, and the Interstate Compact on Adoption and Medical Assistance.</p> <p>In addition, I hereby certify that the attached agreement is a true copy of the most current Adoption Assistance Agreement for the named child(ren) in the files of my office and is effective unless the residence state is notified that it has been terminated by the adoption assistance state.</p> <p>Signed at:</p>			
City		State	
This	day of	20	
Signature:			
Name:			
Title:		Agency:	
Telephone: - - (ext)			

DISTRIBUTION: Send original with one (1) copy of current adoption assistance agreement to (new) Residence State, one(1) copy to adoptive parent(s),retain one(1) file copy in issuing office.