

ACTION: Final

EXISTING
Appendix
5101:2-44-05.2

DATE: 06/17/2019 10:04 AM

NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

DATE REQUESTED FOR MEDICAID OPENING	- - (Please use digits)
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DATE OF MEDICAID CLOSURE	- - (Please use digits)	(in agreement state)
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A. REFERRAL INFORMATION

FROM:

To see the ICAMA Form Administrator for each state go to:
<http://aaicama.org/cms/index.php/icama-forms/icama-primary-contacts-full-information>

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Name		American Indian/Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown
*Social Security # (SSN) <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>					
Birthdate - - <i>(Please use digits)</i>	Ethnicity*	<input type="checkbox"/>					
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Hispanic/Latino <i>*Check if applicable</i>					
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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Name		American Indian/Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown
*Social Security # (SSN) <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>					
Birthdate - - <i>(Please use digits)</i>	Ethnicity*	<input type="checkbox"/>					
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Hispanic/Latino <i>*Check if applicable</i>					
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	Race*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Name		American Indian/Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown
*Social Security # (SSN) <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>					

Birthdate - - <i>(Please use digits)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity* <input type="checkbox"/> Hispanic/Latino <i>*Check if applicable</i>
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Basis of Medicaid eligibility <i>(Check only one)</i>	Adoption Assistance <input type="checkbox"/> Title IV-E <input type="checkbox"/> State-funded	Guardianship Assistance Program <input type="checkbox"/> Title IV-E GAP
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2. ADOPTIVE PARENT(S)/GUARDIAN(S):

Parent/Guardian 1- Name:

Parent/Guardian 2- Name:

3. ADDRESS IN NEW OR CURRENT RESIDENCE STATE:

FAMILY ADDRESS: (Include: Name, Mailing Address, Telephone Number, and E-mail Address)

County: *(if known)*

E-mail: AND/OR Telephone:

4. PREVIOUS ADDRESS (if applicable):

PRIOR FAMILY ADDRESS:
Include: Name, Mailing Address, Telephone Number, and E-mail Address

County: *(if known)*

E-mail: AND/OR Telephone:

(If not the same as in Section 3 above)

5. CHILD IS NOT RESIDING WITH ADOPTIVE PARENT(S)/GUARDIAN(S):

For information purposes only. Case remains open and child remains eligible for Medicaid despite absence from adoptive home.

<input type="checkbox"/> <i>Inpatient Residential Treatment</i>	<input type="checkbox"/> <i>School</i>	<input type="checkbox"/> <i>Temporary absence from home</i>	<input type="checkbox"/> <i>Other (explanation below)</i>
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Other