

**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

**Gender:**  Male  Female

*\*Check if applicable*

*(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

**Gender:**  Male  Female

*\*Check if applicable*

*(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

**Gender:**  Male  Female

*\*Check if applicable*

**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**  **IS NOT**  the Adoption Assistance State

**E. CERTIFICATION**

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.

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.

Signed at:  
 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.