ACTION: Original ICAMA FORM 7.01 OHIO WorkPage ATE: 12/14/2021 10:21 AM

NOTICE OF MEDICALD FLIGIBILITY/CASE ACTIVATION

DATE REQUESTED FOR MEDICAID OPENING		-	- (Please use d	igits)			
DATE OF MEDICAID CLOSURE (Please	- e use digi	(in ag	reeme	nt state)				
A. REFERRAL INFORMATION								
FROM:								
To see the ICAMA Form Administrator for each state go http://aaicama.org/cms/index.php/icama-forms/icama		y-contacts-ful	l-inforr	nation				
TO: Include: Name, Agency, Mailing Address, Telephone Nu	mber, Fa	x Number and I	E-mail A	ddress				
B. CH	ILD INF	ORMATION	N .					
1. NAME/BIRTHDATE/SOCIAL SECURITY NUM	1BER E	TC.						
Child A								
Legal Name	Race*	American Indian/ Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown	
*Social Security # (SSN)		Native	*	,				
Required to open Medicaid case (do not use dashes)	-		*Ch	eck all boxes t	hat are applicable	?		
Birthdate Gender Male Female	Ethnicity*	Hispanic/Latino *Check if applicable						
Basis of Medicaid eligibility Adoption		Assistance Guardianship Assistance Program						
(Check only one)	S	state-funded		Title IV-E	GAP			
Child B								
Legal Name	Race*	American Indian/ Alaskan	Asian	Black /African American	Native Hawaiian/ Other Pacific	White	Unknown	
*Social Security # (SSN)		Native			Islander			
Required to open Medicaid case (do not use dashes)		Native	*Ch	eck all boxes t		?		
Required to open Medicaid case (do not use dashes) Birthdate Gender Male Female	Ethnicity*	Native Hispanic/La *Check if appl	tino	eck all boxes t	Islander hat are applicable	?		
Birthdate Gender Male Female		Hispanic/La	tino licable					
Birthdate - Gender Male Female	Assista	Hispanic/La	tino licable		hat are applicable			
Birthdate - Gender Male Female Basis of Medicaid eligibility Adoption	Assista	Hispanic/La *Check if appl	tino licable	ırdianship A	hat are applicable			
Birthdate Gender Male Female Basis of Medicaid eligibility (Check only one) Title IV-E	Assista	Hispanic/La *Check if appl ance State-funded	tino licable Gua	<i>ırdianship A</i> Title IV-E (hat are applicable Ssistance Prog	ıram	Unknown	

Notice of Medicaid Eligibility/Case Activation – Revised 2014 (01.19.18 Ohio))

Birthdate (Please use digits)	Gender Male Hispanic/Latino *Check if applicable								
Basis of Medicaid eligibilit	Adoptio	on Assistance	Guardianship Assistance Program						
(Check only one)	Title IV-E	State-funded	☐ Title IV-E GAP						
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:	A	ND/OR Telephone	2:						
4. PREVIOUS ADDRESS (if applicable):									
PRIOR FAMILY ADDRESS: Include: Name, Mailing Address, Telephone Number, and E-mail Address County: (if known)									
E-mail:	A	AND/OR Telephone:							
(If not the same as in Section 3 above)									
5. CHILD IS NOT RESIDIN	IG WITH ADOPTIVE	PARENT(s)/GUARDIA	AN(s):						
For information purposes only. <u>Case remains open</u> and child remains eligible for Medicaid despite absence from adoptive home.									
Inpatient Residentia Treatment	School	Temporary abs							
Other									