

ACTION: Original

EXISTING  
Appendix  
5101:2-44-05.2

DATE: 04/10/2019 10:24 AM

NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

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

**FROM:**

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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.**

<b>Child A</b>	<b>Race*</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Legal Name</b>		American Indian/ Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown	
* <b>Social Security # (SSN)</b> <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>						
<b>Birthdate</b> - - <i>(Please use digits)</i>	<b>Ethnicity*</b>	<input type="checkbox"/>						
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Hispanic/Latino <i>*Check if applicable</i>						
<b>Basis of Medicaid eligibility</b> <i>(Check only one)</i>	<b>Adoption Assistance</b>			<b>Guardianship Assistance Program</b>				
	<input type="checkbox"/> Title IV-E			<input type="checkbox"/> State-funded			<input type="checkbox"/> Title IV-E GAP	

<b>Child B</b>	<b>Race*</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Legal Name</b>		American Indian/ Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown	
* <b>Social Security # (SSN)</b> <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>						
<b>Birthdate</b> - - <i>(Please use digits)</i>	<b>Ethnicity*</b>	<input type="checkbox"/>						
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Hispanic/Latino <i>*Check if applicable</i>						
<b>Basis of Medicaid eligibility</b> <i>(Check only one)</i>	<b>Adoption Assistance</b>			<b>Guardianship Assistance Program</b>				
	<input type="checkbox"/> Title IV-E			<input type="checkbox"/> State-funded			<input type="checkbox"/> Title IV-E GAP	

<b>Child C</b>	<b>Race*</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Legal Name</b>		American Indian/ Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown	
* <b>Social Security # (SSN)</b> <i>Required to open Medicaid case (do not use dashes)</i>		<i>*Check all boxes that are applicable</i>						

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