ACTION: Original

ENACTED Appendix 5101:2-44-05.2

ICAMA FORM 7.01 OHIO WorkPage

DATE: 04/24/2018 9:19 AM NOTICE OF MEDICAID ELIGIBILITY/ **CASE ACTIVATION**

DATE REQUESTED FOR MEDICAID OPENING					(Please use digits)							
DATE OF MEDICAID CLC	- se use di	gits)	(in agr	reeme	nt state)							
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												
Legal Name				America Indian Alaska Native	/ n	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown		
*Social Security # (SSN)				Native	-	* ~ 1						
Required to open Medicaid case (do not use dashes)			*	*Check all boxes that are applicable Thispanic/Latino *Check if applicable *Check all boxes that are applicable *The check if applicable								
Birthdate (Please use digits)	Gender Male Female			Hispa *Check	nic/Lati							
Basis of Medicaid eligibility Adoption			n Assis	Assistance			Guardianship Assistance Program					
(Check only one)	-,	Title IV-E		State-fun	nded		Title IV-E	GAP				
Child B												
Legal Name			Race*	America Indian Alaska	/ n	Asian	Black /African American	Native Hawaiian/ Other Pacific	White	Unknown		
*Social Security # (SSN) Required to open Medicaid case (do not use dashes)				Native	9	*Ch	eck all boxes t	Islander hat are applicable	•			
Birthdate		nder Male	Ethnicity*	Hispa	□ nic/Lati	ino						
(Please use digits)		Female		*Check	if applic	-1						
Basis of iviedicald eligibility			Assistance			Guardianship Assistance Program						
(Check only one)		Title IV-E		State-fun	ided		Title IV-E	GAP				
Child C												
Legal Name			}	America		Asian	Black	Native	White	Unknown		
3			Race*	Indian Alaska	•		/African American	Hawaiian/ Other Pacific				
*Social Security # (SSN)			~	Native	9			Islander				
Required to open Medicaid case (do not use dashes)				*Check all boxes that are applicable								

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

Birthdate (Please use digits)	Gender Male Female	Hispanic/Latin									
Basis of Medicaid eligibility	Adoptio	n 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:	1A	ND/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:	l: AND/OR Telephone:										
(If not the same as in Section 3 ab	ove)										
5. CHILD IS NOT RESIDING WITH ADOPTIVE PARENT(s)/GUARDIAN(s): For information purposes only. <u>Case remains open</u> and child remains eligible for Medicaid despite absence from adoptive home.											
Inpatient Residential Treatment	☐ School	Temporary abs	I I I I I I I I I I I I I I I I I I I	below)							
Other											