ACTION: Revised

RESCINDED
Appendix
5101:2-44-05.2

DATE: 05/03/2018 1:32 PM

ICAMA FORM 6.01
NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

A. CHILD IDENTIFYING INFORMATION

1. NAME/BIRTHDATE/SOCIAL SECURITY NUMBER ETC:

(a) Child A's Name

Social Security #

Birthdate: - -

Gender: ☐ Male ☐ Female

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*

(b) Child B's Name:

Social Security #

Birthdate: - -

Gender: ☐ Male ☐ Female

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*

(c) Child C's Name:

Social Security #

Birthdate: - -

Gender: ☐ Male ☐ Female

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*

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 <u>NOT</u> provide Medicaid to children with state funded adoption assistance as an optional Medicaid group.

2. THE ADOPTION ASSISTANCE STATE ☐ DOES ☐ DOES <u>NOT</u> provide Medicaid to children receiving <u>state funded</u> 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.*