NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

DATE REQUESTED FOR MEDICAID OPENING	- - *(Please use digits)*
DATE OF MEDICAID CLOSURE	- - *(Please use digits)* *(in agreement 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

***Social Security #** (SSN)
Required to open Medicaid case (do not use dashes)

Birthdate - - *(Please use digits)*

Gender ☐ Male ☐ Female

Race ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black /African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown
**Check all boxes that are applicable*

Ethnicity ☐ Hispanic/Latino
**Check if applicable*

Basis of Medicaid eligibility *(Check only one)*

Adoption Assistance ☐ Title IV-E ☐ State-funded

Guardianship Assistance Program ☐ Title IV-E GAP

Child B

Legal Name

***Social Security #** (SSN)
Required to open Medicaid case (do not use dashes)

Birthdate - - *(Please use digits)*

Gender ☐ Male ☐ Female

Race ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black /African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown
**Check all boxes that are applicable*

Ethnicity ☐ Hispanic/Latino
**Check if applicable*

Basis of Medicaid eligibility *(Check only one)*

Adoption Assistance ☐ Title IV-E ☐ State-funded

Guardianship Assistance Program ☐ Title IV-E GAP

Child C

Legal Name

***Social Security #** (SSN)
Required to open Medicaid case (do not use dashes)

Race ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black /African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown
**Check all boxes that are applicable*

Birthdate - - *(Please use digits)*	**Gender** ☐ Male ☐ Female	***Ethnicity**** ☐ Hispanic/Latino **Check if applicable*	

Basis of Medicaid eligibility *(Check only one)*	***Adoption Assistance*** ☐ Title IV-E ☐ State-funded	***Guardianship Assistance Program*** ☐ 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: 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.

☐	*Inpatient Residential Treatment*	☐	*School*	☐	*Temporary absence from home*	☐	*Other (explanation below)*

Other