ICAMA FORM 6.01
NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

SECTION A **CHILD(REN) IDENTIFYING INFORMATION**

1. CHILD A

First Name	MI	Last Name

Birthdate	Social Security Number	Gender		Race
MM DD YY		☐ Male	☐ Female	

CHILD B

First Name	MI	Last Name

Birthdate	Social Security Number	Gender		Race
MM DD YY		☐ Male	☐ Female	

CHILD C

First Name	MI	Last Name

Birthdate	Social Security Number	Gender		Race
MM DD YY		☐ Male	☐ Female	

2. ADOPTIVE PARENT(S)

Father's Name	Mother's Name

3. ADOPTIVE PARENT(S) CURRENT ADDRESS

Mailing Address	City	State	Zip Code

County	Telephone Number
	( )

4. ADOPTIVE PARENT(S) NEW RESIDENCE ADDRESS

Mailing Address	City	State	Zip Code

County	Telephone Number
	( )

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 Option**
CHILD B	☐ **Title IV-E/SSI**	☐ **Title IV-E/AFDC**	☐ **State Option**
CHILD C	☐ **Title IV-E/SSI**	☐ **Title IV-E/AFDC**	☐ **State Option**

7. DATE OF MEDICAID CLOSURE (*Last day of the month the child is living in the sending state.)*

CHILD A	CHILD B	CHILD C

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8. DATE REQUESTED FOR MEDICAID OPENING (*First day of the month the child is living in the receiving state.)*

CHILD A	CHILD B	CHILD C

SECTION B MEDICAID COVERAGE FOR STATE-FUNDED CHILDREN

1. The Adoption Assistance State ☐ **DOES** ☐ **DOES NOT** provide Medicaid to children with state-funded adoption assistance as an optional Medicaid group.

2. The Adoption Assistance State ☐ **DOES** ☐ **DOES NOT** provide Medicaid to children receiving state-funded adoption assistance from another ICAMA member state if the child was eligible to receive it in the adoption assistance state

SECTION C OTHER MEDICAL COVERAGE

1. Does child continue to be eligible for other medical assistance from the adoption assistance state?

CHILD A	CHILD B	CHILD C
☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

2. Does child have other third party coverage through any program, organization, or person?

CHILD A	CHILD B	CHILD C
☐ **Yes** ☐ **No** ☐ **Unknown**	☐ **Yes** ☐ **No** ☐ **Unknown**	☐ **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

SECTION D REFERRAL INFORMATION

FROM:

Compact Administrator's Name — Telephone Number

Mailing Address — City — State — Zip Code

FAX Number — Email Address

TO:

Compact Administrator's Name — Telephone Number

Mailing Address — City — State — Zip Code

FAX Number — Email Address

State Status: Current residence state ☐ **IS** ☐ **IS NOT** the Adoption Assistance state.

SECTION 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(s) and the Interstate Compact on Adoption and Medical Assistance.

In addition, I hereby certify that the attached copy/ies of the most current Adoption Assistance Agreement(s)for the named child(ren) in the files of my office is/are true.

Signed at _____ this _____day of _____, _____
City State Month Year

_____ _____
Signature Print Name

_____ _____ _____
Title Agency Date

Distribution: *Send original with one (1) copy of current adoption assistance agreement to (new) Residence State, one (1) copy to adoptive parent(s) and one (1) file copy issuing office.*