

**ICAMA FORM 6.01  
NOTICE OF MEDICAID ELIGIBILITY/CASEACTIVATION**

**A. CHILD IDENTIFYING INFORMATION**

**I. NAME/BIRTHDATE/SOCIAL SECURITY NUMBER ETC:**

**(a) Child A's Name:**

**Social Security #**

*Enter as: 000-00-0000*

**Race\***

Amer Indian  
Alaskan Nat

Asian

Black/African  
American

Native Hawaiian/  
Other Pacific Islander

White

Unknown

*\*Check all boxes that are applicable*

**Birthdate:**   
*Enter as: 00/00/00*

**Ethnicity\***

Hispanic/Latino

**Gender:**  Male  Female

*\*Check if applicable*

**(a) Child B's Name:**

**Social Security #**

*Enter as: 000-00-000*

**Race\***

Amer Indian  
Alaskan Nat

Asian

Black/African  
American

Native Hawaiian/  
Other Pacific Islander

White

Unknown

*\*Check all boxes that are applicable*

**Birthdate:**   
*Enter as: 00/00/00*

**Ethnicity\***

Hispanic/Latino

**Gender:**  Male  Female

*\*Check if applicable*

**(a) Child C's Name:**

**Social Security #**

*Enter as: 000-00-000*

**Race\***

Amer Indian  
Alaskan Nat

Asian

Black/African  
American

Native Hawaiian/  
Other Pacific Islander

White

Unknown

*\*Check all boxes that are applicable*

**Birthdate:**   
*Enter as: 00/00/00*

**Ethnicity\***

Hispanic/Latino

**Gender:**  Male  Female

*\*Check if applicable*

**2. ADOPTIVE PARENTS:**

Parent 1- Name: Steve Clark

**Race\***Amer Indian  
Alaskan Nat

Asian

Black/African  
AmericanNative Hawaiian/  
Other Pacific Islander

White

Unknown

*\*Check all boxes that are applicable***Ethnicity\***

Hispani c/Latino

*\*Check if applicable*

Parent 2- Name:

**Race\***Amer Indian  
Alaskan Nat

Asian

Black/African  
AmericanNative Hawaiian/  
Other Pacific Islander

White

Unknown

*\*Check all boxes that are applicable***Ethnicity\***

Hispani c/Latino

*\*Check if applicable***3. CURRENT FAMILY ADDRESS:**

Number and Street: 250118 Chimney Rock Drive

County: Tarrant

City: Forest Hill

State: TX

Zip: 76140-0000

*Enter 2 letters**Enter as: 00000-0000*

Telephone: (000) 000-0000 (ext )

*Enter as: 000-000-0000***4. FAMILY ADDRESS IN NEW RESIDENCE STATE:**

Number and Street: 1616 Conway Street

County: Ramsey

City: St. Paul

State: MN

Zip: 55103-0000

*Enter 2 letters**Enter as: 00000-0000*

Telephone: (612) 546-5987 (ext )

*Enter as: 000-000-0000*

**5. IF CHILD IS NOT RESIDING WITH ADOPTIVE PARENTS GIVE REASON:\***

*\*If additional explanatory room is needed please use page 7 of this form*

**6. BASIS OF MEDICAID ELIGIBILITY:**

Child A	<input type="checkbox"/> Title IV-E/SSI <input type="checkbox"/> Title IV-E\AFDC <input checked="" type="checkbox"/> State Funded Adoption Assistance/Medicaid Option
Child B	<input type="checkbox"/> Title IV-E/SSI <input type="checkbox"/> Title IV-E\AFDC <input type="checkbox"/> State Funded Adoption Assistance/Medicaid Option
Child C	<input type="checkbox"/> Title IV-E/SSI <input type="checkbox"/> Title IV-E\AFDC <input type="checkbox"/> State Funded Adoption Assistance/Medicaid Option

**7. DATE OF MEDICAID CLOSURE** City of Reno, NV is the child is living in the originating state

Child A:	<div style="border: 1px solid black; background-color: #ffffcc; padding: 5px; width: 100px;">11/30/09</div> <small>Enter as: 00-00-00</small>	Child B:	<div style="border: 1px solid black; background-color: #ffffcc; width: 100px; height: 30px;"></div> <small>Enter as: 00-00-00</small>	Child C:	<div style="border: 1px solid black; background-color: #ffffcc; width: 100px; height: 30px;"></div> <small>Enter as: 00-00-00</small>
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**8. DATE REQUESTED FOR MEDICAID OPENING** City of Reno, NV is the child is living in the originating state

Child A:	<div style="border: 1px solid black; background-color: #ffffcc; padding: 5px; width: 100px;">12/01/09</div> <small>Enter as: 00-00-00</small>	Child B:	<div style="border: 1px solid black; background-color: #ffffcc; width: 100px; height: 30px;"></div> <small>Enter as: 00-00-00</small>	Child C:	<div style="border: 1px solid black; background-color: #ffffcc; width: 100px; height: 30px;"></div> <small>Enter as: 00-00-00</small>
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**B. MEDICAID COVERAGE FOR STATE-FUNDED CHILDREN**

**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 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	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	
Child B	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Child C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

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

Child A	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	
Child B	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	
Child C	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	

**3. LIST SOURCES OF MEDICAL COVERAGE OR BENEFITS:**

Child A	<input type="checkbox"/> SSI	<input type="checkbox"/> SSA	<input type="checkbox"/> TRICARE	<input type="checkbox"/> PRIVATE INSURANCE
Child B	<input type="checkbox"/> SSI	<input type="checkbox"/> SSA	<input type="checkbox"/> TRICARE	<input type="checkbox"/> PRIVATE INSURANCE
Child C	<input type="checkbox"/> SSI	<input type="checkbox"/> SSA	<input type="checkbox"/> TRICARE	<input type="checkbox"/> PRIVATE INSURANCE

**D. REFERRAL INFORMATION**

**FROM:**

*Compact Administrator's Name:* Sam Jones - Dept. of Family and Protective Services E-559

Number and Street: P.O. Box 88888

County: Travis

City: Austin State: TX Zip: 78714-9030  
*Enter 2 letters Enter as: 00000-0000*

Telephone: (000) 000-0000 (ext )  
*Enter as: 000-000-0000*

**TO:**

*Compact Administrator's Name:* Pau Jones - MN Dept. Human Services

Number and Street: 444 Lafayette Road N

County: Ramsey

City: St Paul State: MN Zip: 55155-0000  
*Enter 2 letters Enter as: 00000-0000*

Telephone: (651) 111-1111 (ext )  
*Enter as: 000-000-0000*

**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

Dallas

State

TX

This

8

day of

December

20

9

*Signature:*

Name:

Carol Smith

Title:

CPS Specialist III

Agency:

TX Dept. of Family and Protective Services

Telephone:

(000) 000-0000

(ext

)

*Enter as: 000-000-0000*

**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.*



**PART 5. IF CHILD IS NOT RESIDING WITH ADOPTIVE PARENTS** *(continued)*

