

# ICAMA FORM 6.01

## NOTICE OF MEDICAID ELIGIBILITY / CASE ACTIVATION

### A. CHILD IDENTIFYING INFORMATION

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#### 1. NAME / BIRTHDATE / SOCIAL SECURITY NUMBER, ETC.:

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

Social Security #:

Race\*

☐ Amer. Indian  
Alaskan Nat.

☐ Asian

☐ Black/African  
American

☐ Native Hawaiian/  
Other Pacific Islander

☐ White

☐ Unknown

\*Check all boxes that are applicable

Birthdate:

Ethnicity\*

☐ Hispanic/Latino

\*Check if applicable

Gender: ☐ Male ☐ Female

##### (b) Child B's Name:

Social Security #:

Race\*

☐ Amer. Indian  
Alaskan Nat.

☐ Asian

☐ Black/African  
American

☐ Native Hawaiian/  
Other Pacific Islander

☐ White

☐ Unknown

\*Check all boxes that are applicable

Birthdate:

Ethnicity\*

☐ Hispanic/Latino

\*Check if applicable

Gender: ☐ Male ☐ Female

##### (c) Child C's Name:

Social Security #:

Race\*

☐ Amer. Indian  
Alaskan Nat.

☐ Asian

☐ Black/African  
American

☐ Native Hawaiian/  
Other Pacific Islander

☐ White

☐ Unknown

\*Check all boxes that are applicable

Birthdate:

Ethnicity\*

☐ Hispanic/Latino

\*Check if applicable

Gender: ☐ Male ☐ Female

#### 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 all boxes that are applicable

Ethnicity\*

☐ Hispanic/Latino

\*Check if applicable

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**3. CURRENT FAMILY ADDRESS:**

Number and Street:

County:

City:

State: Florida

Zip:

Telephone (area code and number): (     )

(ext.:     )

**4. FAMILY ADDRESS IN NEW RESIDENCE STATE:**

Number and Street:

County:

City:

State: Florida

Zip:

Telephone (area code and number): (     )

(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/Cash Assistance ☐ State Option

 Child B: ☐ Title IV-E/SSI ☐ Title IV-E/Cash Assistance ☐ State Option

 Child C: ☐ Title IV-E/SSI ☐ Title IV-E/Cash Assistance ☐ State 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 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: ☐ 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

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**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

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Number and Street:

County:

City:

State: Florida

Zip:

**TO:** Compact Administrator's Name:

Number and Street:

County:

City:

State: Florida

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 issuance of 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 of 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.

City:

State: Florida

This

day of

2005

*Signature:*

Name:

Title:

Agency:

**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 in issuing office.

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