ICAMA FORM 7.01
NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

DATE REQUESTED FOR MEDICAID OPENING	- -
DATE OF MEDICAID CLOSURE	- -

A. REFERRAL INFORMATION

From:
Kansas DCF
PPS Administration
555 S Kansas 4th Flr
Topeka, KS 66603
Fax: 785-368-8159

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

Birthdate - -

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

Birthdate - -

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

Race* ☐ ☐ ☐ ☐ ☐ ☐

Legal Name			American Indian/ Alaskan Native	Asian	Black /African American	Native Hawaiian/ Other Pacific Islander	White	Unknown
***Social Security #** (SSN) *Required to open Medicaid case*			**Check all boxes that are applicable*					
Birthdate - -	**Gender** ☐ Male ☐ Female	***Ethnicity****	☐ Hispanic/Latino **Check if applicable*					

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

Number and Street:
County: *(if known)*
City: State: Zip: -
Telephone: - - (ext) E-mail:

4. PREVIOUS ADDRESS *(if applicable)*:

Number and Street:
County: *(if known)*
City: State: Zip: -
Telephone: - - (ext) E-mail: *(If not the same as in Section 3 above)*

5. CHILD IS NOT RESIDING WITH ADOPTIVE PARENT(s)/GUARDIAN(s): *(Check one)*

Case remains open and child remains eligible for Medicaid despite absence from adoptive home.

- ☐ Inpatient Residential Treatment
- ☐ School
- ☐ Temporary absence from the home (not for school or residential treatment)
- ☐ Other
  Please give brief explanation

C. CERTIFICATION

This is to certify that the records of my agency 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 and the attached Adoption Assistance Agreement or Guardianship Assistance Agreement.

In addition, I hereby certify that the attached agreement(s) is/are a true copy/copies of the most current Adoption Assistance Agreement(s) or Guardianship Assistance Agreement(s) for the named child(ren) in the files of my agency and is/are in effect unless the residence state is notified that it/they has/have been terminated by my agency or state.

Signed at:

City:		State:	

This	day of	20
Signature:		
Name: Title: Agency:	Telephone Number: ( )- - (ext.) E-mail address:	

DISTRIBUTION:
Original with copy of current Adoption Assistance/Guardianship agreement to (new) Residence State
(1) copy to adoptive parent(s)
(1) file copy retained in issuing office

Kansas
Department for Children and Families
Prevention and Protection Services
Strong Families Make a Strong Kansas