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|  | INTERSTATE COMPACT FOR ADOPTION MEDICAL ASSISTANCE (ICAMA)  **ICAMA Request** | | | | | | | | | | | |
| FROM | | | | | | | | | TODAY’S DATE | | | |
| **PLEASE CHECK ONE**  New ICAMA request\*  Change of address within current state  Request to close Medicaid in one state/open in another\*  Request to close out ICAMA (Reason: )  Request to extend ICAMA past age 18\*\*  \*Please attach a copy of the most recent **Adoption Support Agreement** OR **RGAP Guardianship Agreement** with all new ICAMA requests.  \*\*Please attach a letter from the school indicating the child continues to attend school fulltime along with their expected graduation date. | | | | | | | | | | | | |
| CHILD’S NAME | | | GENDER  M / F | | RACE | | DATE OF  BIRTH | SOCIAL SECURITY  NUMBER | | | | IVE?  YES NO |
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| ADOPTIVE or GUARDIANSHIP PARENTS NAMES | | | | | | | | | | | | |
| OLD ADDRESS | | | | | | NEW ADDRESS | | | | | | |
| CITY | | STATE | | ZIP CODE | | CITY | | | | STATE | ZIP CODE | |
| CONTACT NUMBER | | | | | | EMAIL ADDRESS | | | | | | |
| EFFECTIVE DATE | | | | | | | | | | | | |
| ADDITIONAL INFORMATION AS NEEDED: | | | | | | | | | | | | |