|  |  |
| --- | --- |
|  |   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 | GENDERM / F | RACE | DATE OFBIRTH | SOCIAL SECURITYNUMBER | IVE?YES NO |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
|  |  |  |  |  | **[ ]**  **[ ]**  |
| 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: |