DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

May 13, 2002

ALL- COUNTY INFORMATION NOTICE NO I-29-02

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

TO: ALL COUNTY WELFARE DIRECTORS
ALL CDSS ADOPTIONS DISTRICT OFFICES
ALL ADOPTION ASSISTANCE ELIGIBILITY WORKERS
ALL ADOPTION MEDI-CAL WORKERS

SUBJECT: **INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE**

This notice is to inform you of guidelines for the implementation of the Interstate Compact on Adoption and Medical Assistance (ICAMA) in California. See Welfare and Institutions Code Section 16170 through 16177. The ICAMA protects the interests of special needs chldren who receive Adoption Assistance Program benefits and public health care services as they move with their adoptive family from one state to another.

In May 2001, California became a member of the ICAMA. The California Department of Social Services (CDSS) and the Department of Health Services (DHS) are State co-compact administrators of the ICAMA. State administrators work with the Association of Administrators of the ICAMA (AAICAMA), which facilitates the implementation of the compact for all member states in accordance with AAICAMA bylaws, procedures, and forms. All member states must comply with ICAMA procedures and use only the approved ICAMA forms. (Attachments 1, 2, and 3 are ICAMA Forms 6.01, 6.02 and 6.03, respectively.)

RESPONSIBILITIES OF CDSS

As ICAMA Co-Compact Administrator, the CDSS will work with officials in California and other states to facilitate the provision of public health care benefits and services for adopted special needs children. The CDSS also will monitor and enforce compliance with ICAMA guidelines and procedures, provide training, serve as an information resource and act as a liaison for counties, adoptive families and the AAICAMA.

RESPONSIBILITIES OF DHS

As ICAMA Co-Compact Administrator, the DHS will activate, close, or modify a child's Medi-Cal case, as appropriate. The DHS also will provide CDSS with confirmation of changes in health care benefits and services for the child. After reviewing incoming, completed ICAMA Forms 6.01 and 6.03, the DHS will forward them to local agencies.

RESPONSIBILITIES OF COUNTIES

County's Responsibility As A Sending Agency

The county first should verify the child's eligibility for Adoption Assistance Program benefits. A child who is eligible for Title IV-E benefits is automatically eligible to receive Medicaid in the receiving state. However, a child who receives state-funded adoption assistance does not qualify for Medicaid in the receiving state unless that state has a reciprocal agreement with Calfiornia to provide health care services. (Attachment 4 is a list of states that offer reciprocal health care services.) In the absence of such an agreement, the county should advise the adoptive family that the child will retain Medi-Cal eligibility to receive health care services from an out-of-state provider who is willing to accept payment under Medi-Cal.

The county next should prepare an ICAMA request package and send it directly to the compact administrator in the receiving state. (Attachment 5 provides a list of compact administrators, addresses, and telephone numbers. The AAICAMA website, http://aaicama.aphsa.org, has the most current list of ICAMA administrators.) The request package should include the following items: a cover letter, a completed ICAMA form 6.01, and a copy of the child's current Adoption Assistance Agreement. (Attachment 6 is a sample cover letter.) The name of a county contact person should also be provided in case the receiving state has any questions about the request. In addition, the county should send a copy of the completed ICAMA Form 6.01 to the CDSS Out-of-State Placement Policy Unit.

The following ICAMA forms are used to process the ICAMA request for client public health care benefits. The ICAMA Form 6.01 is the “Notice of Medicaid Elgibility/Case Activation," which includes:

- Child's social security number,
- Medi-Cal closure date,
- Family's new address
- Family's new telephone number
- Per CDSS recommendation, the county contact person's name and phone number in the certification box section.

The ICAMA Form 6.02 is the “Notice of Action,” which tells the family that the receiving state has been notified of the child's eligibility to receive Medicaid benefits in the

receiving state. The county should send the family a completed ICAMA Form 6.02, a copy of the ICAMA Form 6.01 that was sent to the receiving state, and a copy of the child's current Adoption Assistance Agreement.

The ICAMA Form 6.03 is the "Report of Change in Child/Family Status," which notifies the receving state of any changes in the child's or family's status, such as change of address, finalization of adoption decree, change of child's name, termination of adoption, or change in eligibility. The receiving state also will use the ICAMA Form 6.03 to notify the county of the child's Medicaid status.

County's Responsibility As A Receiving Agency

The county will receive notice from DHS to activate a Medi-Cal case for a child entering California. The DHS will forward to the county the ICAMA Form 6.01 from the sending state and the child's current Adoption Assistance Agreement. A county that needs additional information to process this form should contact the Compact Administrator in the sending state. The AAICAMA handbook recommends that states process request packages within seven days of receipt.

The county should use ICAMA Form 6.03 to notify the sending state of the activation of Medi-Cal benefits for the child. This form, as previously described herein, is also used for reporting changes in the child's or family's status.

Given the length of time needed to process ICAMA request packages, the county should advise families, upon finalization of the child's adoption, to give their adoption assistance elgibility worker reasonable advance notice of any pending relocation to another state. Such notification will assist in avoiding a lapse in the child's health care coverage in the receiving state.

If you have any questions regarding this notice or have a child leaving California, please contact the CDSS Child Welfare Services Operations and Evaluation Branch by calling Kathy Anderson at (916) 322-5973 or Jackie Rodriguez at (916) 445-0813. Any questions regarding a child entering California should be directed to the DHS Medi-Cal Eligiblity Branch by calling Erin Lynch at (916) 654-5769 or Janeen Jimenez at (916) 657-1248.

Sincerely,

Original Signed by Sylvia Pizzini
On May 13, 2002

Sylvia Pizzini
Deputy Director
Children and Family Services Division

Attachments

ICAMA FORM 6.01
NOTICE OF MEDICAID ELIGIBILITY/CASE ACTIVATION

A. CHILD IDENTIFYING INFORMATION

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

ace:

(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 if applicable*

Ethnicity* ☐ Hispanic/Latino

**Check if applicable*

3. CURRENT FAMILY ADDRESS:

Number and Street:

County:

City: State: Zip

Telephone:

4. FAMILY ADDRESS IN NEW RESIDENCE STATE:

Number and Street:

County:

City: State: Zip

Telephone:

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\AFDC ☐ State Option

Child B: ☐ Title IV-E/SSI ☐ Title IV-E\AFDC ☐ State Option

Child C: ☐ Title IV-E/SSI ☐ Title IV-E\AFDC ☐ 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 <u>NOT</u> provide Medicaid to children with state funded adoption assistance as an optional Medicaid group.

2. THE ADOPTION ASSISTANCE STATE ☐ DOES ☐ DOES <u>NOT</u> provide medicaid to children receiving <u>state funded</u> 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

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

D. REFERRAL INFORMATION		
FROM: *Compact Administrator's Name:*		
Number and Street:		
County:		
City:	State:	Zip
TO: *Compact Administrator's Name:*		
Number and Street:		
County:		
City:	State:	Zip
State Status: Current residence state **IS** ☐ **IS <u>NOT</u>** ☐ 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 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 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		State
This	day of	20
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), one(1) file copy in issuing office.*

This form replaces Form 5.02

ICAMA FORM 6.02
NOTICE OF ACTION

A. NOTIFICATION

TO:

Parents: _____

Address: _____

_____

Telephone #: _____

You have notified us that on or about _____ that your child(ren) will be living at the new address below.
Date

1. Child's Name: _____ ❑ IV-E ❑ State Funded

2. Child's Name: _____ ❑ IV-E ❑ State Funded

3. Child's Name: _____ ❑ IV-E ❑ State Funded

Address: _____

_____

Telephone #: _____

FROM:

Compact Administrator: Jackie Rodriguez, Manager, Out-of-State Placement Policy Unit

Office/Department: Department of Social Services, ATTN: Kathy Anderson, ICAMA Coordinator

Address: 744 P Street, MS 19-78

Sacramento, CA 95814

Telephone #: (916) 445-0813

Date:

B. YOUR NEW RESIDENCE STATE ❑ IS ❑ IS NOT A MEMBER OF THE INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE (ICAMA).

C. CHILDREN RECEIVING IV-E ADOPTION ASSISTANCE

1. ICAMA Form 6.02 notifies you, the adoptive family, that this office has sent the necessary information to your new State of Residence informing it that your child is eligible to receive Medicaid in the State so that Medicaid Identification may be issued.

2. Contact your child's Residence State Adoption Compact Administrator named in Section D of the attached **ICAMA Form 6.01** to determine what steps, if any, you need to take in order to receive a Medicaid Identification Card in your new State of Residence.

3. You may be instructed by the Compact Administrator to contact the Medicaid office to obtain a new Medicaid Identification. You may be asked to complete an assignment of rights for medical support and payment. You may also be asked to provide other necessary information. Your new Medicaid office will also be able to provide you with information about benefits available in the (new) Residence State.

4. If you are moving to a State that is not a member of ICAMA as indicated above, you may need to go to your local Medicaid office with these forms to apply for Medicaid on behalf of your child(ren). If you encounter a problem, contact the Compact Administrator listed on this form.

D. CHILDREN RECEIVING STATE-FUNDED ADOPTION ASSISTANCE

1. If your child is receiving state-funded adoption assistance as indicated in Section A of this form, then your child is not automatically eligible to receive Medicaid in the new State of Residence.

2. If your State of Residence is a member of ICAMA as indicated in Section B of this form, then contact the Compact Administrator in the new State of Residence as identified on **Form 6.01**.

3. IF your new State of Residence is not a member of ICAMA, you need to go to the local department of social services in the new State of Residence and inquire about receiving medical assistance. If you have questions; contact your state's adoption assistance compact administrator as identified in **Form 6.01, Section D.**

ICAMA FORM 6.03
REPORT OF CHANGE IN CHILD\FAMILY STATUS

A. SENDING INFORMATION

TODAY'S DATE: May 16, 2002

FROM: *Compact Administrator's Name:* Number and Street: County:		
City:	State:	Zip
Telephone:		
TO: *Compact Administrator's Name:* Number and Street: County:		
City:	State:	Zip
Telephone:		

REASON FOR REPORTING: (Check appropriate box)

☐ Address Change ☐ Adoption Status Change
☐ Update on Medicaid Status ☐ Change in Case Status

B. CHILD IDENTIFYING INFORMATION

(a) Child A's Name:	Birthdate:	Social Security #
(b) Child B's Name:	Birthdate:	Social Security #
(c) Child C's Name:	Birthdate:	Social Security #

2. ADOPTIVE PARENTS:

Parent 1: Parent 2:

C. CHANGE IN MEDICAID STATUS

Child A	Child B	Child C
Medicaid Case Opened:	Medicaid Case Opened:	Medicaid Case Opened:
Medicaid Effective Date:	Medicaid Effective Date:	Medicaid Effective Date:
Medicaid ID #: *(New residence state)*	Medicaid ID #: *(New residence state)*	Medicaid ID #: *(New residence state)*

D.CHANGE IN CASE STATUS

Child A	Child B	Child C
Effective Date of Change:	Effective Date of Change:	Effective Date of Change:
Change is to ☐ Active ☐ Closed	Change is to ☐ Active ☐ Closed	Change is to ☐ Active ☐ Closed
Effective Date of Closing:	Effective Date of Closing:	Effective Date of Closing:
Reason for Closing:	Reason for Closing:	Reason for Closing:

E. CHANGE IN ADDRESS
1.EFFECTIVE DATE:
2.CURRENT FAMILY ADDRESS: Number and Street: County: State: Zip
Telephone:
3. NEW FAMILY ADDRESS: Number and Street: County: State: Zip
Telephone:

F. CHANGE IN ADOPTION STATUS		
1. EFFECTIVE DATE:		
2. ADOPTION ASSISTANCE AGREEMENT:		
Child A	Child B	Child C
Adoption Assistance State:	Adoption Assistance State:	Adoption Assistance State:
Effective Date *Original agreement*	Effective Date *Original agreement*	Effective Date *Original agreement*
Expiration Date *Original Agreement*	Expiration Date *Original Agreement*	Expiration Date *Original Agreement*
Effective Date *Current Agreement*	Effective Date *Current Agreement*	Effective Date *Current Agreement*
Expiration Date *Current Agreement*	Expiration Date *Current Agreement*	Expiration Date *Current Agreement*
3. FINAL ADOPTION DECREE:		
Child A	Child B	Child C
Pending ☐ Yes ☐ No*	Pending ☐ Yes ☐ No*	Pending ☐ Yes ☐ No*
*Date of Final Decree:	*Date of Final Decree:	*Date of Final Decree:
ICPC Notification Made via 100B ☐ Yes ☐ No	ICPC Notification Made via 100B ☐ Yes ☐ No	ICPC Notification Made via 100B ☐ Yes ☐ No
4. ADOPTION TERMINATED:		
Child A	Child B	Child C
Has Adoption Terminated? ☐ Yes* ☐ No	Has Adoption Terminated? ☐ Yes* ☐ No	Has Adoption Terminated? ☐ Yes* ☐ No
*If Yes, Give Date	*If Yes, Give Date	*If Yes, Give Date

DISTRIBUTION: *Prepare original and two (2) copies. Reporting state retains original (1); recipient state retains one (1); adoptive parents receive one (1).*

Cobra Option/Reciprocity as of March 2002

STATE	COBRA OPTION	RECIPROCITY	COMMENTS
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes *	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	No	*	1
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	No	Will have reciprocity upon executing joinder in ICAMA this year
Florida	Yes	No	
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	No	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	No	No	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	Yes	Reciprocity with all states
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states

* Contact state

[1] Effective October 1, 2000, DCF will use the DO2 state funded medical coverage group to provide health insurance for any child with special needs as determined under section 473c for who there is in effect an adoption assistance agreement between a State and an adoptive parent(s).

STATE	COBRA OPTION	RECIPROCITY	
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	No	Actively working towards obtaining a policy of reciprocity
Nevada	Yes	No	Actively working towards obtaining a policy of reciprocity
New Hampshire	Yes	No	
New Jersey	Yes	No	Will have reciprocity upon executing joinder in ICAMA this year
New Mexico	No	No	
New York	Yes	No	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity will all states
Pennsylvania	Yes	No	Will have reciprocity upon executing joinder in ICAMA this year
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont	Yes	Yes	Reciprocity with all states
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming	Yes	Yes	Reciprocity with all states

Cynthia Goss, Assist. Administrator
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Clare Rehman, Interstate Adoption Coordinator
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Janice Freeman, Program Field Representative-Adoption
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Larry Yarberough, Title IV-E
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Diane Dexter, Adoption Coordinator
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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

Out of State Agency

MEDICAID REQUEST FOR FEDERAL/NON-FEDERAL AAP RECIPIENT

Adoptee(s):
Adoptee Parent(s):

The above named child(ren) who is/are receiving, either Federal (Title IV-E) or state-funded Adoption Assistance Program benefits from California, is/are living in your state. The enclosed Adoption Assistance Agreement from California documents his/her/their eligibility for Medicaid. Both California and your state have a policy of reciprocity with all states to provide Medicaid to children in their state who receive federal or state-funded adoption assistance benefits from other states.

We ask that you forward this referral to the appropriate agency to assist this family in obtaining Medicaid benefits for these children. If you should have any question regarding these children, please contact **CA Agency** at **PHONE NUMBER.**

Sincerely,

Enclosures