



**Division of Children
and Family Services**

P.O. Box 1437, Slot S-571 · Little Rock, AR 72203-1437
501-682-8889 · Fax 501-682-2109 · TDD 501-682-1442



TO: _____
FROM: _____
DATE: _____
SUBJ: ICAMA Medicaid Redetermination

Please complete and return by _____ to continue Medicaid coverage. Failure to respond may cause the Medicaid benefit to be terminated. If you have any questions, please call me at (501) _____ or send an email to _____@dhs.arkansas.gov. Thank you for your assistance.

**CERTIFICATION OF CONTINUED ELIGIBILITY
FOR ADOPTION SUBSIDY WITH MEDICAID BENEFITS**

Adoptive Parent Name(s): _____
Address: _____

Child Information			Certification				
Name	DOB	SSN	There is an adoption subsidy agreement with Medicaid benefits in effect for this child		Type of Subsidy		Effective date if subsidy agreement has terminated
					Title IV-E	State Funded	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	

Comments:

Completed by:

 Name Title Date

 Phone Number Fax Number