CFS 490-17
1/2017

State of Illinois
Department of Children and Family Services

INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE (ICAMA) REFERRAL FORM

THIS FORM MUST BE FULLY COMPLETED BEFORE A REFERRAL CAN BE PROCESSED.

Caseworker Name:________________________________ **Date:**________________

Requested Medical Coverage Start Date: __________________

PARENT(s) Name(s):____

Out of State Address:____
Number/Street City/State/Zip

Phone number:____

CHILD #1 Name:____

DCFS ID Number: ________________ Social Security Number:________________

Birthdate:________________________ Gender: ☐ Male ☐ Female

Race/Ethnicity:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Hispanic/Latino
- ☐ Unknown

CHILD #2 Name:____

DCFS ID Number: ________________ Social Security Number:________________

Birthdate:________________________ Gender: ☐ Male ☐ Female

Race/Ethnicity:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Hispanic/Latino
- ☐ Unknown

CHILD #3 Name:____

DCFS ID Number: ________________ Social Security Number:________________

Birthdate:________________________ Gender: ☐ Male ☐ Female

Race/Ethnicity:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Hispanic/Latino
- ☐ Unknown