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 <u>BE FULLY COMPLETED</u> 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