**Attachment T**

**State of Indiana Contact:**

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Procurement Consultant

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Indiana Department of Administration

**Reference Check Form**

**RFP 26-85248**

Correctional Health Care

Reference Check Form Due Date:

**October 23, 2025, by 3:00PM (Eastern)**

**Any changes will be notated on the RFP Main Document, section 1.24 Summary of Milestones**

**INSTRUCTIONS: Please insert your Company/Vendor Name and complete the blue boxes below. A representative from the State of Indiana may reach out to 1 or more of your references to ask specific questions that may be beneficial to our solicitation. Should you wish to explain anything about this reference to the State, please include those comments where applicable below.**

**Please provide the information requested below and submit the reference information along with your proposal on the Supplier Portal.**

**VENDOR NAME (Vendor submitting this proposal)**

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**REFERENCE CONTACT INFORMATION**

|  |  |
| --- | --- |
| **Reference Company Name** |  |
| **Contact Name** |  |
| **Contact Title** |  |
| **Company Mailing Address** |  |
| **Company City, State, Zip** |  |
| **Company Website Address** |  |
| **Contact Telephone Number** |  |
| **Contact Fax Number** |  |
| **Contact Email** |  |
| **Industry of Company** |  |

QUESTIONS: Please provide a response to each of the questions listed below regarding the reference listed above.

1. What were the dates you worked with this reference:

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1. Please explain the duties that were performed which you feel would be similar in scope to this solicitation:

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1. Please list three (3) items that you felt went well during this interaction:

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1. Please list one (1) item that you feel could have been completed differently which would have resulted in a better outcome:

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1. Please list any additional information that you feel would be beneficial for the State to know regarding your interaction with this reference:

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