

Prior to mailing to CWIC

Please complete the following checklist and mail with referral information to your local CWIC  
Please (x) the appropriate line that has been included with the referral.

CHECKLIST for BINNERS

\_\_\_\_\_ All information is completed concerning the Benefits Screening Profile referral information (e.g. pg. 2. List a specific vocational goal, (desired employment goal) how many hours a week/hourly pay list within additional comments section). Be sure to specify any children living in household, with their names and ages.

\_\_\_\_\_ Types of Medicaid Insurance the individual receives has been verified.

\_\_\_\_\_yes \_\_\_\_\_no

\_\_\_\_\_ Category of Medicaid Insurance

\_\_\_\_\_ MAD

\_\_\_\_\_ MADW

\_\_\_\_\_ 1619B

\_\_\_\_\_ Medicaid Select

\_\_\_\_\_ Medicaid Waiver

\_\_\_\_\_ IRIS number (must be requested from Vocational Rehabilitation Counselor).

\_\_\_\_\_ BPOY Consent forms, authorizing information released to Indiana Works (2 are required).

\_\_\_\_\_ The Indiana Works/ Southern Indiana Resource Solutions consent for release of confidential information is complete and your agency name is written on the Release/Request form.

\_\_\_\_\_ Vocational Rehabilitation (V. R.) counselor name and any payee/guardian guardian information

\_\_\_\_\_ V.R. Counselor Name

\_\_\_\_\_ Payee name if applicable

\_\_\_\_\_ Release for Department of Family Resource (must include release if individual is receiving Medicaid)

\_\_\_\_\_ The Strategic Plan included

Signature of individual completing the check list \_\_\_\_\_ Date \_\_\_\_\_