NEW YORK STATE DEPARTMENT OF HEALTH

Bureau of Supplemental Food Programs, WIC Program

WIC Vendor Application

IMPORTANT: **All items must be completed, unless otherwise indicated. If this application is incomplete, it will be returned to you. All information provided in and with this application must be current as of the date that the application is submitted to the WIC Local Agency.**

PART I - STORE IDENTIFICATION

1. FOOD STAMP AUTHORIZATION NUMBER_____

Attach copy of food stamp authorization. **Food stores without food stamp authorization should contact the WIC Local Agency**. Pharmacies are not required to have food stamp authorization.

2. STORE TRADE NAME_____

3. TAX INFORMATION

FEDERAL

If the store has one, write in the Federal Employer Identification Number (FEIN) used to report business tax information to the Internal Revenue Service. |___|___| - |___|___|___|___|___|___|___|

If the FEIN is under a different business name than the store name, write in the name of the business to which the FEIN is assigned. _____

If the store does not have an FEIN and the store's taxes are reported to the Internal Revenue Service under the Social Security Number (SSN) of one of the owners, then write the name of the owner whose SSN is used to report business taxes. _____

STATE

Sales tax number_____

Attach a copy of the store's stamped New York State Sales Tax Certificate of Authority.

4. IS THIS A CHAIN STORE? (Definition: A chain store is ONE OF A GROUP OF THREE OR MORE similarly identified retail stores under one corporate ownership or franchiser). If YES, write in chain store unit number, if any, and quantity of stores owned in NYS. **YES ❑** **NO ❑**

|___|___|___|___|___|___|___|___|___|___|

_____ **(quantity owned in NYS)**

5. STORE ADDRESS

A. PHYSICAL LOCATION

Street Number_____ Street Name_____

City_____

County_____State|___|___| Zip |____|____|____|____|____|-|____|____|____|____|

- Indicate any other street address that this store has at the same location (for example: different street entrances or street names): _____
- Indicate the nearest intersections/cross streets to the store and provide directions from the nearest intersection/cross street: _____

_____

_____

B. MAILING ADDRESS

Office/Apartment Number_____ Street Number_____

Street Name/Rural Route No./P.O. Box_____

City_____State|___|___| Zip|___|___|___|___|___|-|___|___|___|___|

6. STORE TELEPHONE NUMBER Area Code _____ Number_____-_____

7. STORE FAX NUMBER Area Code _____ Number_____-_____

8. STORE E-MAIL ADDRESS _____

9. STORE MANAGER IDENTIFICATION – Name of the person with primary on-site responsibility for daily operations.

First Name_____ Last Name_____

Date of Birth Month_____ Day____ Year_____

If this is a chain store, indicate district manager's name.

First Name_____ Last Name_____

Date of Birth Month_____ Day____ Year_____

PART II - STORE OWNERSHIP AND MANAGEMENT

1. TYPE OF OWNERSHIP- Check one type:

❑ Sole Proprietorship ❑ Privately-held corporation ❑ Cooperative IS THIS STORE A FRANCHISE?
❑ Partnership ❑ Publicly-owned corporation ❑ Government-owned ❑ YES ❑ NO

2. OWNERSHIP IDENTIFICATION

A. NAME AND ADDRESS OF THE BUSINESS IF IT IS DIFFERENT FROM STORE TRADE NAME ON PAGE 1. (For example, a parent corporation.)

Business Owner's Name_____

Legal Address of Business: Street Number_____ Street Name/P.O. Box _____

City_____ State|___|___| Zip Code|___|___|___|___|___|-|___|___|___|___|

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B. OWNERS' NAMES and HOME ADDRESSES – In the appropriate section below, enter requested information for owners of sole proprietorships, partnerships, or officers of a corporation. **WRITE NAME EXACTLY AS SHOWN ON OWNERS'S SOCIAL SECURITY CARD. WRITE THE NAMES OF THE OWNERS/OFFICERS IN THE ORDER OF PRIORITY IN WHICH YOU WANT THEM TO RECEIVE MAIL/CORRESPONDENCE FROM WIC.**

SOLE PROPRIETORSHIP OR PARTNERSHIP If there are more than three owners, attach additional sheets providing the same information as requested below.

1. First Name _____ Last Name_____

   Title_____ Date of Birth Month_____ Day____ Year_____

   Home Address and Telephone Number: Telephone _(_____)_____

   Street Number_____ Street Name/P.O. Box_____

   City_____ State|___|___| Zip Code|___|___|___|___|___|-|___|___|___|___|

2. First Name _____ Last Name_____

   Title_____ Date of Birth Month_____ Day____ Year_____

   Home Address and Telephone Number: Telephone _(_____)_____

   Street Number_____ Street Name/P.O. Box_____

   City_____ State|___|___| Zip Code|___|___|___|___|___|-|___|___|___|___|

3. First Name _____ Last Name_____

   Title_____ Date of Birth Month_____ Day____ Year_____

   Home Address and Telephone Number: Telephone _(_____)_____

   Street Number_____ Street Name/P.O. Box_____

   City_____ State|___|___| Zip Code|___|___|___|___|___|-|___|___|___|___|

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CORPORATION (Attach certificate of incorporation and list all corporate officers below.)

1. Name of Corporation_____

   Chief Executive Officer_____

   Address – Principal Executive Office

   Street Number_____ Street Name/P.O. Box_____

   City_____State_____Zip Code_____

   Phone No. ( ) _____Fax No. ( ) _____

   E-Mail Address _____

2. Corporate Officers

   President
   Name_____Date of Birth _____

   Home Address Number and Street_____

   City_____State_____Zip Code_____

   Phone No. ( )_____Fax No. ( ) _____

   E-Mail Address_____

   Vice President (If there is more than one vice president, attach a sheet with the same information requested for each VP.)

   Name_____Date of Birth_____

   Home Address Number and Street_____

   City_____State_____Zip Code_____

   Phone No. ( )_____Fax No. ( ) _____

   E-Mail Address_____

   Secretary
   Name_____Date of Birth_____

   Home Address Number and Street_____

   City_____State_____Zip Code_____

   Phone No. ( )_____ Fax No. ( ) _____

   E-Mail Address_____

Treasurer
Name_____Date of Birth_____

Home Address Number and Street_____

City_____State_____Zip Code_____

Phone No. ( )_____Fax No. ( ) _____

E-Mail Address_____

3. **Corporate Authorized Representative** – Person legally authorized to sign for corporation

Name_____Date of Birth_____

Title: _____

Business Address Number and Street_____

City_____State_____Zip Code_____

Phone No. ( )_____Fax No. ( ) _____

E-Mail Address_____

C. BUSINESS INTEGRITY

During the last six (6) years has the vendor applicant or any of the vendor applicant's current owners, officers, or managers been convicted of or had a civil judgment entered against them for any activity indicating a lack of business integrity including but not limited to: fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims or obstruction of justice?

❑ Yes ❑ No.

⇨ **If the answer to the question above is Yes**, attach a written explanation, giving the name of the person(s) who was convicted of or has had a civil judgment entered against them for the above activity indicating a lack of business integrity; their relationship to the owner, partner, or corporate entity; and their current or past position, if any, in the store or corporation. Attach a copy of the certificate of criminal conviction or civil judgment.

In order to properly identify vendors, the New York State Department of Health and WIC Local Agency reserve the right to photograph and/or fingerprint store owners, contract signatories, managers and employees.

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PART III – STORE AND OWNERSHIP HISTORY

Did you buy or start the retail store business for which you are applying?

❑ Buy. Answer questions 1 through 13 below. Attach a signed and dated copy of the bill of sale for the store.
❑ Start. Answer questions 1 through 5 below. Attach a statement declaring that this is a new business.

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1. Have you previously, or do you presently own, manage, or have a financial interest in any other store(s) or pharmacy(ies)? Financial interest means an investment in the business or receipt of income from the business.

❑ Yes. ❑ No.

If yes, list the vendor number (if store is/was a contractor with the WIC Program), store name, relationship to the business, and address for each store. (If there are more than three stores, attach additional sheets providing the same information as requested below.) If the relationship is a financial interest, describe the nature of the financial interest.

	VENDOR NO.	RELATIONSHIP DATE	STORE NAME & ADDRESS
a.		Owned ❑ from:____/_____/_____ Managed ❑ to: _____/_____/_____ Financial Interest ❑ (describe) _____ _____	
b.		Owned ❑ from:____/_____/_____ Managed ❑ to: _____/_____/_____ Financial Interest ❑ (describe) _____ _____	
c.		Owned ❑ from:____/_____/_____ Managed ❑ to: _____/_____/_____ Financial Interest ❑ (describe) _____ _____	

Were any of the stores (those listed above **and the applicant store**) or present owners (including corporations and partners) or employees of the stores (those listed above **and the applicant store**) ever fined, non-renewed, disqualified, terminated, suspended or denied participation by the WIC or Food Stamp Programs?

❑ Yes. ❑ No.

If yes, indicate which store(s)/owner(s)_____

If yes, please check all box(es) that apply:

❑ WIC ❑ Fined ❑ Disqualified ❑ Non-Renewed
❑ Terminated ❑ Denied Participation
❑ Food Stamps ❑ Fined ❑ Disqualified ❑ Denied Participation
❑ Terminated ❑ Suspended

2. Do you own the building in which the business is located?

❑ Yes. Provide a deed or copy of the contract of sale for the building.
❑ No. Provide a copy of a signed and dated lease agreement.

3. Does the previous owner of the building have any financial interest in or hold a mortgage on the applicant store business or the building the business is operating in?

❑ Yes. Describe_____

❑ No. Date the previous owner of the building ceased all involvement with operation of the store:

_____/_____/_____
month day year

4. Do you presently employ or contract in any capacity with any previous owner(s) of this building?

❑ Yes. List names and indicate whether each individual is an employee or contractor.

_____

_____

_____

_____

_____

❑ No.

5. When did (or will) the applicant store open for business under current ownership? _____/_____/_____
month day year

_____

Applicants who started the applicant business may skip the following questions 6 through 13 and proceed to Part IV of the application. **Applicants who purchased the applicant business must complete questions 6 through 13 below**.

6. What was the date of closing of the sale of the business? _____/_____/_____
month day year

7. What was the trade name of the store you purchased? _____

8. Was the store an authorized WIC vendor prior to your buying it?

❑ Yes. Indicate WIC Vendor Number if Known _____
❑ No.
❑ Unknown.

9. From whom did you buy this business? (Complete one.)

a. Name of person _____

b. Name of partnership _____

c. Name of corporation _____

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10. Are you related by blood, marriage or adoption to any of the former owner(s), partner(s), or corporate officer(s) of the store?

    ❑ Yes. Indicate name and relationship_____
    Name Relationship

    ❑ No.

11. Were you an owner, partner, corporate officer or employee of the business you purchased?

    ❑ Yes. If yes, please specify: ❑ Owner ❑ Partner ❑ Corporate Officer ❑ Employee
    ❑ No.

12. Do any of the former owners, partners, corporate officers, managers, or employees of the business you purchased have a financial interest in the applicant business or are any of them current owners, corporate officers, managers, employees, or contractors of the applicant business? (Financial interest means an investment in the business or receipt of income from the business.)

    ❑ Yes. Complete table below. If more than five individuals, attach additional sheets indicating the information requested in the table.

Name of Individual	**Current Role in Applicant Business**	**Role in Business Under Previous Ownership**

    ❑ No. Date the previous owner of the business ceased all involvement with operation of the store:
    _____/_____/_____
    month day year

13. If this store was previously owned and operated under another name(s), please list the former store trade name(s) and former owner(s).

Former Store Name(s)	Former Owner(s)

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PART IV – STORE TYPE AND HOURS

1. Type of store (Check all that apply):

❑ FRANCHISE	A store operated by an individual, partnership or corporation that has been granted the right to market a parent company's merchandise.
❑ CONVENIENCE	Owned by an individual, partnership or corporation, stocking primarily "convenience items" (e.g., bread, milk, eggs and sundries).
❑ INDEPENDENT	Up to two stores which are owned by a single individual, partnership or corporation and which do not have the buying power of a group.
❑ PHARMACY	Licensed by the NYS Education Dept. to operate in this state.
❑ COMMISSARY	Department of Defense facility only.
❑ OTHER	E.g., a cooperative. Please describe: _____ _____ _____

2. Hours of Business

Open 24 hours, 7 days a week ❑ Yes ❑ No
If no, list hours your store is open for business:

	Opens	Closes
Sunday	_____	_____
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____

PART V – STORE CHARACTERISTICS

1. Number of Employees _____
2. Square footage of store _____
3. Number of operating cash registers _____
4. Is there video surveillance of cash registers? ❑ Yes ❑ No
5. Number of operating scanners _____
6 Number of operating scanners that can identify WIC authorized foods versus non-WIC foods _____

7. Does your store have any rolling (mobile) store locations or delivery routes? ❑ Yes ❑ No

If yes, please describe: _____
_____

8. Gross Annual Sales Amounts

Existing Stores:
Provide gross annual TOTAL sales for the last 12 months _____
Provide gross annual FOOD sales for the last 12 months _____

New Stores:
Provide a projected amount of gross annual TOTAL sales for 12 months _____
Provide a projected amount of gross annual FOOD sales for 12 months _____

Is more than 50% of your gross annual FOOD sales for the next 12 months expected to come from WIC checks?

❑ Yes ❑ No

9. Sole bank account number for deposit of WIC checks _____
(Attach Bank Designation Form)

10. Bank Information

Bank name_____

Address_____

City_____State_____Zip Code_____

Phone No. ( ) _____ Fax No. ( )_____

E-Mail Address_____

11. Do you sell alcoholic beverages? ❑ Yes ❑ No If yes, indicate liquor license number_____

12. Do you sell lottery tickets? ❑ Yes ❑ No

13. Who is your primary grocery wholesaler?

Name _____

Address_____

City_____State_____Zip Code_____

Phone No. ( ) _____ Fax No. ( )_____

Who is your primary infant formula supplier? (Attach proof that you purchase/will purchase infant formula from this supplier - for example: a letter from the supplier, invoices for one month, etc.)

Name_____

Address_____

City_____State_____Zip Code_____

Phone No. ( ) _____ Fax No. ( )_____

List any occasional infant formula suppliers:

Name_____

Address_____

City_____State_____Zip Code_____

Phone No. ( ) _____ Fax No. ( )_____

Name_____

Address_____

City_____State_____Zip Code_____

Phone No. ( ) _____ Fax No. ( )_____

14. Do you primarily sell kosher foods? ❑ Yes ❑ No

15. Indicate the date of the most recent inspection of your store by the New York State Department of Agriculture and Markets. _____/_____/_____
month day year

Attach a copy of the Notice of Inspection indicating that no critical deficiencies were observed or that critical deficiencies were corrected at the time of inspection.

The WIC Vendor Application is required by the Director, Bureau of Supplemental Food Programs, Division of Nutrition, New York State Department of Health, Albany, NY 12204-2719, under the authority of 10NYCRR 60-1 and 7CFR 246. The information is used to determine whether the applicant vendor meets eligibility requirements, to collect information used for statistical purposes and to have accurate mailing and contact information. Failure to provide the requested data may result in the denial of your WIC Vendor Application.

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I understand that submitting this application does not constitute authorization to participate in the WIC Program or permit me to accept WIC checks or Special Formula Food Instruments and that there are fines and penalties for accepting and redeeming WIC checks or Special Formula Food Instruments without authorization to do so. I also understand that I may be liable to the State of New York for any and all WIC checks accepted or redeemed without authorization to do so. I understand that if I provide any false information, this may result in this application being treated as incomplete or denied or my disqualification from the WIC Program. Under the penalty of perjury, I affirm that each statement contained within this application is true.

By signing this application I agree to stock WIC acceptable foods in the varieties and quantities as identified by the New York State Department of Health in the attached Minimum Stock Requirements document as a condition of receiving authorization to participate in the New York State WIC Program. I understand that prior to authorization my store will be monitored for compliance with the stocking requirements. I acknowledge that my application will be denied if I fail to stock the required foods as specified in the Minimum Stock Requirements document.

I authorize my bank of deposit to release to the New York State Department of Health my bank signature card and application at any time without a subpoena. I authorize all persons, governmental or business entities, or any other entities, to release any and all information, both verbal and written, regarding myself or my business to the New York State Department of Health or its representative whenever they are requested to do so. I authorize the New York State Department of Health or its representative to release any and all information they obtain relative to my WIC Program application to any and all other governmental entities in accordance with 7 CFR 246.26(e). A photocopy of this authorization shall be considered as effective as the original.

Name (print)_____ Title_____

Signatory must be legally authorized to enter into a contract on behalf of the store. Agents, lessees and powers of attorney are not acceptable applicants or signatories for this application or for the Vendor Contract.
Signature_____ Date_____

Name of Application Preparer_____
(if different from above)

Phone No. ( )_____Fax No. ( )_____

E-Mail_____

State of _____
County of _____ ss: _____
On the _____ day of _____, 20_____, before me personally appeared _____, to me known, did duly swear or affirm that he/she resides at _____, that he/she is the sole owner/part owner/corporate officer (circle one) of the store described herein and that he/she affirms that each statement contained within this application is true.

_____
NOTARY PUBLIC

Standards for participation in the WIC Program are the same for everyone. If you believe you have been discriminated against because of race, color, national origin, age, sex, or handicap, write immediately to the Secretary of Agriculture, Washington, D.C. 20250. If you feel you have been discriminated against based on marital status, religion or political belief, call the toll-free NYS Growing Up Healthy Hotline at 1-800-522-5006.

No fee is charged by the state or WIC local agencies to become a WIC vendor or to obtain, complete or process a WIC application.