



Attached is a **SAMPLE** vendor application. This is a duplicate of the online vendor application. Please use this **SAMPLE** vendor application to review the questions and ensure the correct individual is completing the online application. Do not submit this as a vendor application.

## Preliminary Application Activities

Before beginning a vendor application to become a WIC authorized vendor in Mississippi, please review the information below.

- I. Review the Vendor Selection Criteria at [www.msdh.ms.gov](http://www.msdh.ms.gov) under the WIC Vendor Information section.
- II. Review the Vendor Authorization Process at [www.msdh.ms.gov](http://www.msdh.ms.gov) under the WIC Vendor Information section.
- III. Review attached sample application
- IV. Gather supporting documents

### Retail Grocers

1. Business license
2. Form W-9
3. Food permit
4. Copy of lease, deed, or other proof of ownership
5. SNAP permit
6. Store brand declaration form
7. Additional Store Attachment (if more than one physical location)
8. WIC price survey (for each location)
9. Store brand declaration form

### Pharmacies

1. Business license
2. Form W-9
3. Copy of lease, deed, or other proof of ownership
4. SNAP permit
5. Additional Store Attachment (if more than one physical location)
6. WIC price survey (for each location)

### Commissaries

1. Form W-9
2. Copy of lease, deed, or other proof of ownership
3. SNAP permit
4. Store brand declaration form
5. WIC price survey (for each location)

- V. Discuss this information within your business to ensure you are authorized to complete and electronically sign the application.
- VI. Locate the online application link [www.msdh.ms.gov](http://www.msdh.ms.gov) under the WIC Vendor Information section.
- VII. Complete and submit the entire online application.

**Mississippi State Department of Health WIC Program  
Vendor Application**

Submission of this application **does not** constitute authorization to participate in the Mississippi State Department of Health WIC Program (MSDH WIC Program). This application is **NOT** an Agreement. Participation in the MSDH WIC Program will not be authorized until all completed application materials have been received, evaluated, and approved.

**PLEASE ANSWER ALL QUESTIONS, ATTACH DOCUMENTATION, AND SIGN.  
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**

Select (x) One:

- New Application
- Add Additional Location
- Re- Authorization; Enter Vendor Number: \_\_\_\_\_

**BUSINESS INFORMATION**

If this is a business with multiple stores, please enter information for the parent business here, and the information for each additional store seeking authorization on the 'Additional Store Attachment'.

Business Name (DBA): \_\_\_\_\_

Federal ID Number: \_\_\_\_\_

Physical Business Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address (if different from physical address): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

The legal structure of this business is:

- |  |  |
|--|--|
| <input type="checkbox"/> Corporation                   | <input type="checkbox"/> Sole Proprietorship |
| <input type="checkbox"/> Commissary                    | <input type="checkbox"/> Partnership         |
| <input type="checkbox"/> Limited Liability Corporation |  |

If applicable, name of partner(s): \_\_\_\_\_

If applicable, date and place (city and state) of incorporation/organization: \_\_\_\_\_

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**CONTACT INFORMATION:**

This information pertains to the owner, partner, member, or corporate officer responsible for the operation of the business. If a Partnership or Corporation, please enter percent of ownership.

Name: \_\_\_\_\_ % Ownership (if applicable) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SECONDARY CONTACT INFORMATION:**

Enter information for an additional authorized representative. This is optional.

Name: \_\_\_\_\_ % Ownership (if applicable) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**BANK INFORMATION:**

Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**TRAINING INFORMATION:**

Specify the name of the individual(s) who will be responsible for WIC oversight and training of vendor personnel on WIC procedures and communicating WIC program changes to the cashiers other interested parties.

***Vendor Training Representative(s)***

Enter information for an additional authorized representative. This is optional.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Other: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

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Vendor Application**

**BUSINESS MODEL TYPE**

Select 1 (one) business model from the list below. If you are unsure, please refer to the table below.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mass Merchandiser      | <input type="checkbox"/> Local Grocery Chain | <input type="checkbox"/> National Drug Chain          |
| <input type="checkbox"/> National Grocery Chain | <input type="checkbox"/> Independent Grocery | <input type="checkbox"/> Regional or Local Drug Chain |
| <input type="checkbox"/> Regional Grocery Chain | <input type="checkbox"/> Commissary          |   |

Category	Description
Mass Merchandiser	Retailer that sells a wide variety of merchandise but also carries groceries and has outlets in most or all states
National Grocery Chain	Retailer that primarily sells groceries with outlets in more than 30 states
Regional Grocery Chain	Retailer that primarily sells groceries with at least 11 outlets and operates in 2- 30 states
Local Grocery Chain	Retailer that primarily sells groceries with at least 11 outlets and operates in only 1 state
Independent Grocery	Retailer that primarily sells groceries with less than 11 outlets in only 1 state
Commissary	Grocery store operated by the US Department of Defense Commissary Agency within the confines of a military institution; it may fit within any of the grocery formats
National Drug Chain	Pharmacy retailer with outlets in more than 30 states
Regional or Local Drug	Pharmacy retailer that is not a national drug chain

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**STORE INFORMATION**

Actual Annual Food Sales:  
\$ \_\_\_\_\_

Estimated Annual Food Sales from WIC:  
\$ \_\_\_\_\_

Actual Annual Food Sales from SNAP:  
\$ \_\_\_\_\_

Actual Annual Food Sales from Other Sources:  
\$ \_\_\_\_\_

Square Footage (Food Area Only): \_\_\_\_\_

Number of Cash Registers (Do not include self-checkout or departmental checkouts): \_\_\_\_\_

SNAP Authorized? Please select only one option.  Yes  No  Pending

SNAP Number: \_\_\_\_\_ SNAP Authorization Date: \_\_\_\_\_

Yes  No

Does this store feature a full, well-stocked line of grocery items with three (3) or more brands from which to choose among most food lines?

Yes  No

Under the Mississippi State Department of Health WIC Vendor Agreement, you will be required to stock a minimum of five (5) types of fresh fruits and vegetables for participants. Does this location have the space and/or ability to comply?

Yes  No

Does this store feature non-grocery items as its major retail products?

Yes  No

Do you expect that more than 50 percent of your annual revenue from the sale of food items will be derived from WIC?

Yes  No

During the last six (6) years, have you or any current owner, officer or manager been convicted of or received a civil judgment for 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?

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Yes  No

Has the store or its owner(s), officer(s), or manager(s) ever been suspended or disqualified from WIC in any state?

If yes, give the name of the owner(s), officer(s), manager(s), and vendor(s) location, and the reason(s) and date(s) of suspensions or disqualifications.

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Yes  No

Has the store, its owners, officers or managers ever been suspended or disqualified (or received a civil monetary penalty assessed in lieu of disqualification for hardship) from the SNAP in Mississippi or any other state?

If yes, give the name of the owners, managers, any officers, vendor(s), location(s), the reason(s) and date of suspension or disqualification:

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Yes  No

Has the store ever been cited by the State or County health inspector for a violation?

If yes, was your license/permit revoked? \_\_\_\_\_  
If yes, when? From: \_\_\_\_\_ to \_\_\_\_\_

Yes  No

Does this store location have internet access?

If yes, who is your service provider? \_\_\_\_\_

Yes  No

Are your cash registers currently eWIC capable (programmed to detect WIC Authorized vs. Non-Authorized products)?

If so, in what states: \_\_\_\_\_

Yes  No

Is there a conflict of interest (relationship) between your store and any local or state WIC agency?

If yes, please explain:

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Days and hours of normal store operation:

This location is open 24 hours a day 7 days a week.

OR

Sunday	Open (enter time):	Close (enter time):
Monday	Open (enter time):	Close (enter time):
Tuesday	Open (enter time):	Close (enter time):
Wednesday	Open (enter time):	Close (enter time):
Thursday	Open (enter time):	Close (enter time):
Friday	Open (enter time):	Close (enter time):
Saturday	Open (enter time):	Close (enter time):

Name and address of infant formula wholesaler or supplier:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name and address of primary grocery wholesaler:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name and address of milk wholesaler:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Name and address of pharmacy wholesaler (if pharmacy applicant):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**PROCESSES FOR FOOD SALES TRANSACTIONS:**

Does your store have a Point of Sale device?

Yes     No

Please select all forms of payment your store will be accepting.

Cash     EBT     Debit     Credit     Checks

**Please select the picture that best describes how your store currently does or plans on doing WIC transactions. Please circle ONE image only.**

A cash register and a separate POS device



**Stop! Proceed to next page**

ONLY a cash register with built-in EBT capabilities (integrated)



**Please continue below**

1. What company did or will do your WIC integrated software come from?
2. Who processes or will process your WIC reimbursements?

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**Attachments**

Please attach the following documents:

**Business License**

**Proof of Ownership**

**Form W-9**

**Food Permit**

**Proof of SNAP authorization**

**Store Brand Declaration**

**WIC Price Survey (If different, for each location.)**

**Additional Store Attachment (If you are submitting one application for multiple stores.)**

**General Information**

PLEASE READ CAREFULLY AND SIGN BELOW

The undersigned is authorized to act on behalf of the applicant identified on Page 1, who is applying for authorization to participate in the MSDH WIC Program. By submitting this application, **the undersigned has declared that the business is open, fully operational, and authorized to accept SNAP.** The undersigned has reviewed, verified, and understands the information contained in and attached to this vendor application packet.

Submission of this application **does not** constitute authorization to participate in the MSDH WIC Program. This application is **NOT** an Agreement. Participation in the MSDH WIC Program will not be authorized until all completed application materials have been received, evaluated, and **approved.** The MSDH WIC Program or its designee may verify the information contained in this application during an on-site visit.

1. I certify that the enclosed Price Monitoring Survey form reflects the actual highest shelf price.
2. I certify that all information submitted on this application is accurate and complete.
3. I understand that if the application is approved and an Agreement is executed, I will be bound by all rules, and requirements of the MSDH WIC Program, in addition to the terms and conditions of the Mississippi State Department of Health WIC Vendor Agreement.
4. I understand that if any information contained in this application is found to be false, the application will be denied, or if authorized, can result in being suspended or disqualified from participating in the MSDH WIC Program.
5. The undersigned declares that he/she is the vendor's sole owner or has the delegated legal authority to sign this application on behalf of the owner.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Title (Print): \_\_\_\_\_

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**For Agency Use Only:**

Vendor ID: \_\_\_\_\_

Peer Group: \_\_\_\_\_

Contract Start Date: \_\_\_\_\_

Contract End Date: \_\_\_\_\_

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To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture  
  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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