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'.

Legal Business Name (DBA): _____

Store Name (if different from Business Name): _____

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:

☐ Corporation ☐ Sole Proprietorship
☐ Commissary ☐ Partnership
☐ Limited Liability Corporation

If applicable, name of partner(s): _____

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

PRIMARY 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) _____

Date of Birth: _____ Social Security Number: _____

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) _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Other: _____ Cell: _____

Email Address: _____

Mailing address (if different): _____

City: _____ State: _____ Zip Code: _____

WIC CONTACT INFORMATION:

Specify the name of the individual who will be responsible for WIC communications with the MSDH WIC Vendor Management Unit.

WIC Contact Representative

Enter information for WIC Contact Representative.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Other: _____ Cell: _____

Email Address: _____

TRAINING REPRESENTATIVE 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 or other store representatives.

Vendor Training Representative(s)

Enter information for training representative.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Other: _____ Cell: _____

Email Address: _____

BUSINESS MODEL TYPE

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

- ☐ Mass Merchandiser
- ☐ National Grocery Chain
- ☐ Regional Grocery Chain
- ☐ Local Grocery Chain
- ☐ Independent Grocery
- ☐ Commissary
- ☐ National Drug Chain
- ☐ Regional or Local Drug Chain

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): _____

Self-Check Out? ☐ Yes ☐ No If yes, how many? _____

Federal ID Number: _____

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

SNAP Number: _____ SNAP Authorization Date: _____

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):

BANK INFORMATION:

Bank Name: _____

Bank Routing Number: _____ Bank Account Number: _____

Telephone Number: _____ Email Address: _____

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WHOLESALER(S) INFORMATION:

Name and address of infant formula 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: _____

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

VENDOR ELIGIBILITY QUESTIONS:

Select 1 (one) answer for the following questions:

☐ 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?

☐ 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.

_____

☐ 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:

☐ 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:

Grocery Store Attachments

Grocery store applicants attach the following documents:

Business license or Privilege Tax license

Retail Food Establishment license

Proof of ownership (Lease, Deed, or Bill of Sale)

Form W-9

Vendor Technology Survey

Additional Store Attachment (For entities submitting one application for multiple stores)

Proof of SNAP authorization

Grocery Price Survey

Store Brand Declaration Form

Pharmacy Attachments

Pharmacy applicants attach the following documents:

Business license or Privilege Tax license

Proof of ownership (Lease, Deed, or Bill of Sale)

Form W-9

Vendor Technology Survey

Additional Store Attachment (For entities submitting one application for multiple stores)

Pharmacy license

Pharmacy Price Survey

Vendor Technology Survey

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 all information submitted on this application is accurate and complete.
2. 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.
3. 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.
4. 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: _____

Title: _____

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, 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.

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