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 under the WIC Vendor Information section.

II. Review the Vendor Authorization Process at 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 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:
☐ 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:  ______________________

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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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Mississippi State Department of Health WIC Program
Vendor Application

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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**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
- [ ] Independent Grocery
- [ ] Regional Grocery Chain
- [ ] Commissary

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass Merchandiser</td>
<td>Retailer that sells a wide variety of merchandise but also carries groceries and has outlets in most or all states</td>
</tr>
<tr>
<td>National Grocery Chain</td>
<td>Retailer that primarily sells groceries with outlets in more than 30 states</td>
</tr>
<tr>
<td>Regional Grocery Chain</td>
<td>Retailer that primarily sells groceries with at least 11 outlets and operates in 2-30 states</td>
</tr>
<tr>
<td>Local Grocery Chain</td>
<td>Retailer that primarily sells groceries with at least 11 outlets and operates in only 1 state</td>
</tr>
<tr>
<td>Independent Grocery</td>
<td>Retailer that primarily sells groceries with less than 11 outlets in only 1 state</td>
</tr>
<tr>
<td>Commissary</td>
<td>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</td>
</tr>
<tr>
<td>National Drug Chain</td>
<td>Pharmacy retailer with outlets in more than 30 states</td>
</tr>
<tr>
<td>Regional or Local Drug</td>
<td>Pharmacy retailer that is not a national drug chain</td>
</tr>
</tbody>
</table>

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STORE INFORMATION

Actual Annual Food Sales: $__________________
Actual Annual Food Sales from SNAP: $__________________

Estimated Annual Food Sales from WIC: $__________________
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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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.

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:

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 __________________

Does this store location have internet access?

If yes, who is your service provider? ______________________

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

If so, in what states: ________________________________

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

<table>
<thead>
<tr>
<th>Day</th>
<th>Open (enter time):</th>
<th>Close (enter time):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
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<tr>
<td>Monday</td>
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<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Thursday</td>
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<tr>
<td>Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________

“This institution is an equal opportunity provider.”
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

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

Stop! Proceed to next page

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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In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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: 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.

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