Completion of this application does not assure authorization to participate in WIC

WIC PROGRAM
Vendor Application
(Do not duplicate this form)

Store/Business

Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Telephone # _____ **Fax #** _____

Main Office

Contact Person Name _____

Title _____ **Telephone #** _____ **Fax #** _____

Mailing Address _____

Store/Business Hours _____ No. Of Employees _____

Annual Volume of Sales $_____ No. Of Registers _____

Employee ID # (FEIN) _____ Pharmacy Phone # _____

Pharmacy License # _____
(Authorization is required prior to approval if applicable)

Health Department License # _____ Expiration date: _____
(Food Protection License) (Authorization is required prior to approval)

Food Stamp Certification # _____ Issued date: _____
(Authorization is required prior to approval) Pharmacies excluded

Type of Business/Vendor Class ( ) Grocery ( ) Grocery + Pharmacy
(Check one only) ( ) Pharmacy ( ) Other (Specify) _____

a. Ownership Information

9 Sole Proprietorship (1) 9 Publicly owned corporation (4) 9 Limited Liability Company (7)
9 Partnership (2) 9 Cooperative (5)
9 Privately-held corporation (1) 9 Government owned (6)

Is this store a franchise? 9 Yes 9 No

b. If more than one store/outlet is authorized under same ownership check here ____ and give details.

_____

c. If sole proprietorship, list spouse, manager, clerk, etc. If a partnership, list all partners including yourself.

(circle one)
Owner/Partner Name **Mr./Mrs./Ms.** _____
(circle one)
Home Address _____

Home Telephone No. _____

Social Security No. _____

(circle one)
Spouse name **Mr./Mrs./Ms.** _____

Social Security No. _____

(circle one)
Partner and/or Manager Name **Mr./Mrs./Ms.** _____
(and/or person who operates the store when owner is not in)

Home Address _____

Home Telephone No. _____

Social Security No. _____

d. If a corporation, list name, title and social security number of each executive officers. If you have all positions, please state it.

Corporation Name _____

(circle one)
President Name **Mr./Mrs./Ms.** _____

Home Address _____

Home Telephone No. _____

Social Security No. _____ No. of Shares_____

(circle one)
Vice President Name **Mr./Mrs./Ms.** _____

Home Address _____

Home Telephone No. _____

Social Security No. _____ No. of Shares_____

(circle one)
Secretary Name **Mr./Mrs./Ms.** _____

Home Address _____

Home Telephone No. _____

Social Security No. _____ No. of Shares_____

(circle one)
Treasurer Name **Mr./Mrs./Ms.** _____

Home Address _____

Home Telephone No. _____

Social Security No. _____ No . of Shares_____

(circle one)
Manager Name **Mr./Mrs./Ms.** _____
(and/or person who operates the store when owner is not in)

Home Address _____

Home Telephone No. _____

Social Security No. _____

(circle one)
Pharmacy Manager and/or **Mr./Mrs./Ms.** _____

Home Address _____

Home Telephone No. _____

Social Security No. _____ License # _____

e. Yes 9 No 9 Are any of the persons listed above also owner officer, partner or manager of any other **authorized** Rhode Island WIC vendor?

If yes, give name and location _____

f. Yes 9 No 9 Are any of the persons listed above also owner, partner, officer or manager of any other **NON** WIC authorized food store or pharmacy?

If yes, give name and location _____

g. Yes 9 No 9 Does any owner, partner, officer or manager own any other WIC authorized store (**IN ANY STATE**)?

If yes, give name and location _____

h. Yes 9 No 9 Has any owner, partner, officer, manager or **any relative** ever been a participating WIC or Food Stamp vendor in any USDA, state or local agency?

If yes, give name and location _____

i Yes 9 No 9 Has there been a change of ownership or control in the past year?

If yes, give date and details _____

- ***Date you acquired/bought your business/store:*** _____

Name of store then _____

j. Yes 9 No 9 Is any change of ownership or control anticipated in the next fifteen months?

If yes, give date and details _____

k. (The term Vendor, below refers to the business and/or any person having owner, officer or partner interest or managerial control of the applicant business). The Questions apply to Vendor history in any state.

Yes 9 No 9 Has the Vendor ever been, or is the Vendor presently disqualified from participation in any FCS Program, such as Food Stamps or WIC?

Yes 9 No 9 Are there any charges pending against the Vendor for any violation of the rules or regulations of any FCS Program?

Yes 9 No 9 Has the Vendor ever received any notice of charges or sanction, sentence, or disqualification for any violation of the rules or regulations of any FCS Program?

Yes 9 No 9 Has the Vendor ever been assessed a civil money penalty, fine, probation, USDA or court settlement by any Food and Consumer Service (FCS) Program such as food Stamps or WIC?

Yes 9 No 9 Is the Vendor, to your knowledge being investigated for such violations?

Yes 9 No 9 Has the Vendor ever received administrative or judicial review of any administrative or judicial action related to an FCS Program?

Yes 9 No 9 Has any owner, officer, or manager ever been convicted of any felony?

If yes, give details _____

If yes to any of the above questions, give details and dates of any such disqualification, sanction, sentence, civil money penalties, investigation, or review.

_____

Do you possess a liquor license? Yes Θ No Θ

..... If yes, give License No. _____

(If you possess this license, special conditions/requirements apply.) (Please inquire)

Length of time operated in present location under present ownership _____

- Do you understand that you may **NOT ACCEPT** any WIC checks until you receive written notice from the WIC Program of authorization to do so, a Vendor Participation Agreement signed by RIDH, a WIC Vendor stamp and the penalties for unauthorized acceptance of WIC checks---------- Yes

- Have you read all the information sent to you on WIC and understand your responsibilities as a WIC Vendor? ..... Yes

* Do you understand that you have to notify the WIC Program **BEFORE** you do any business changes like: ownership, new partner(s), corporate members, address, telephone, bank, etc..... Yes

* Do you understand that the WIC VENDOR STAMP is issued to the original store owner/applicant and is not transferable during a change of business ownership, including business composition ..... Yes

- Do you understand that you will be accountable for WIC Program compliance by your employees? ..... Yes

- Are you willing to assist in periodic on-site reviews of your WIC business and procedures ..... Yes

- Do you agree to attend the next scheduled WIC Vendor Training Session whether it be while your application is pending or after you have been accepted for participation? (This is a requirement) ..... Yes

- Do you understand that there are required quantities and types of WIC foods that you must stock and maintain at all times? (Refer to enclosed Minimum Inventory Requirement List). ..... Yes

- Do you understand that WIC abuse or fraud may result in the loss of your Food Stamp Authorization? ..... Yes

- Do you understand that violations of Food Stamp Program rules may result in loss of your WIC Program authorization even if not disqualified from the Food Stamp Program? ..... Yes

Standards for merchant participation in WIC are the same for everyone regardless of race, color, national origin, age, sex, handicap, religious or political belief.

Name of Vendor's Bank _____ Address _____

Bank Account Number _____

Affix your ***Deposit Stamp,*** if you have one, and/or attach a ***copy of your cash register endorsement***

Bank	**Food Stamp**	**WIC**

This application becomes part of the subsequent WIC Vendor Participation Agreement, if approved.

- If you need assistance in understanding any part of this form, please call 222-4621 for an explanation.
- Si necesita ayuda en comprender esta carta, por favor llame al 222-4621 donde le ayudaràn con la traducciòn
- All applications will be considered according to order of receipt and the Program's need for new vendors and must be notarized.

Please fill out the attached price sheet and return it with this completed application and all the required photocopies of your proof of ownership.

I, _____, CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ANY SUPPORTING DOCUMENTS IS TRUE TO THE BEST OF MY KNOWLEDGE.

A TRUE STATEMENT MADE UNDER THE PENALTIES OF PERJURY

_____ _____ _____

Date Applicant's Original Signature Print Name

STATE OF _____ COUNTY OF _____ IN _____

IN SAID COUNTY, ON THIS _____ DAY OF _____ 2000, PERSONALLY APPEARED

BEFORE ME _____ OF _____

Applicant's Name City

WHO MADE OATH THAT THE FACTS STATES ABOVE ARE TRUE.

_____

Notary Public Original Signature

_____

Notary Public Print Name

I understand that WIC Program officials may verify any information relating to this application; that I will notify this department of any changes, and that if I have contributed to any misrepresentation of falsification of information or commit any violations of the rules and regulations of the WIC Program participation as a WIC Vendor, I will be subject to denial and/or

ACH AUTHORIZATION AGREEMENT

(Completion of this agreement is required prior to approval)

Attach (tape) here a blank voided check from an established account:

Attach (tape) here a blank deposit slip from your account:

INSTRUCTIONS for page number 6:

	Check list (Y)	
(1)	_____	Complete store/business name, today's date and store telephone number
(2)	_____	Store address, city, state and zip code
(3)	_____	Bank account holder's name and title
(4)	_____	Complete original account holder's signature
(5)	_____	Complete band information
(6)	_____	Attach a blank voided check from an established account to ensure your ACH entry is correctly applied
(7)	_____	Make a copy of the ACH AUTHORIZATION AGREEMENT form for your records and file in your RIDH-WIC Program Vendor Participation Agreement
(8)	_____	I (we) understand that I (we) should notify the RIDH of any changes on the above information

Si necesita ayuda en comprender esta carta, por favor, llame al 222-4621 donde le ayudaràn con la traducciòn.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATION
DEPARTMENT OF HEALTH
WIC PROGRAM

AUTOMATED CLEARINGHOUSE (ACH) AUTHORIZATION AGREEMENT FOR REIMBURSEMENT CREDITS (ACH CREDITS) AND PENALTY OR FEE COLLECTION (ACH DEBITS)

BUSINESS NAME _____ DATE _____

STORE NAME _____ TELEPHONE NO. _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

OWNER'S NAME _____
(PRINT)

ACCOUNT HOLDER'S NAME _____ TITLE _____
(PRINT)

ACCOUNT HOLDER'S SIGNATURE _____
(Original authorized signature)

I (we) hereby authorize and request the RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM, hereinafter called RIDH, to initiate and effect **Reimbursement Credit and/or Penalty or Fee Collection** entries of any amounts owing by RIDH to me (us) and any amounts owing by me (us) to RIDH as such amounts become due by initiating **Reimbursement Credit and/or Penalty or Fee Collection** (and the ability to perform a reversal of an erroneous transaction) entries related to WIC transactions to my (our) checking and/or savings account indicated in the bank name(s) below, hereinafter called **BANK** and I (we) authorize and request the **BANK** to direct/accept the entries related to WIC transactions initiated by **RIDH** to such account(s) without responsibility for the correctness thereof:

DEPOSITORY BANK NAME _____ TELEPHONE NO.( ) _____

BANK ADDRESS _____

CITY _____ STATE _____ ZIP _____

ROUTING NUMBER _____ ACCOUNT NUMBER _____

Please verify your routing and account number with your bank or business office before completing this section.

I (we) with the above signature, certified that all the above information is true. I understand that WIC Program officials may verify any information relating to this certification; and that if I (we) have contributed to any misrepresentation or falsification of information, participation as a WIC Vendor will be subject to denial and/or termination from the WIC Program up to three years, claim for reimbursement and possible disqualification from the Food Stamp Program and criminal prosecution.

This authorization is to remain in full force and effective until the RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM has received written notification from me (us) of its termination.

This form should be completed (for each store) by either the store owner, partner or a WIC register authorized agency only.

Register Information

1. Total number of Registers _____

2. Number of Registers with scanners _____

   a. If you do have Registers with scanners:

      - Can they **scan** WIC items? **Yes** _____ **No** _____

      - Can they **code** WIC totals? **Yes** _____ **No** _____

3. Number of Registers with credit card readers _____ Total

   a. POS (point-of-sale) _____

   b. EBT Terminals **(required prior to approval)** _____

   c. Pin Pad _____