

DATE OF REQUEST: \_\_\_\_\_

WIC-14b  
Rev. 6/10

## KENTUCKY WIC PROGRAM DRUG STORE APPLICATION

Please Print unless otherwise indicated.

*ALL QUESTIONS ON THE APPLICATION MUST BE PROPERLY AND FULLY COMPLETED. PLEASE REVIEW THE WIC INFORMATION MANUAL FOR VENDOR APPLICANTS FOR INSTRUCTIONS ON COMPLETING THIS FORM.*

1. STORE NAME \_\_\_\_\_

2. MAILING ADDRESS (Do not complete if mail can be delivered to the store's physical location.):

STREET #/ NAME \_\_\_\_\_

RURAL ROUTE NUMBER/P.O. BOX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

3. PHYSICAL STORE ADDRESS:

STREET # \_\_\_\_\_ STREET NAME \_\_\_\_\_

CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

4. STORE TELEPHONE NUMBER: ( \_\_\_\_\_ ) \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Area Code Number

5. E-MAIL ADDRESS \_\_\_\_\_

6. TYPE OF STORE (Check One):  Grocery  Convenience  Other Specify \_\_\_\_\_

7. TYPE OF OWNERSHIP (Check One):  Single Owner  Partnership  Corporation

8. OWNERSHIP INFORMATION:

A. CORPORATION NAME AND ADDRESS (For any business that is incorporated):

CONTACT PERSON: \_\_\_\_\_ , \_\_\_\_\_ TITLE: \_\_\_\_\_  
Last Name First Name

BUSINESS NAME: \_\_\_\_\_

STREET #/ NAME: \_\_\_\_\_

P.O. BOX: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE NUMBER: ( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code Number



**Privacy Act Statement:** The collection of the Social Security Number (SSN) is authorized by Section 2018 of Title 7, US Code and will be used to determine whether a store qualifies to participate in the WIC Program, to monitor compliance with Program regulations; and for Program management. The provision of the SSN's will be available only to officers and employees whose duties or responsibilities require access for the administration or enforcement of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) and the Food Stamp Act.

**B. OWNER(S) NAME(S), SOCIAL SECURITY NUMBER(S) AND TELEPHONE NUMBER(S):**

(Complete for single owners, partnerships, principal shareholders of private corporations, corporate officers, etc. Include spouse, if spouse is considered an owner. Attach a listing if more convenient.)

Name \_\_\_\_\_, \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_, \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_, \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

Name \_\_\_\_\_, \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name

9. **MANAGER (if different from Owner):** \_\_\_\_\_, \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Last Name First Name

10. When did (or will) the store open for business under the applying ownership?     
Month Day Year

11. How long has this store been in business? \_\_\_\_\_  
 Was this store previously operated under another name or owner?  Yes  No  
 If yes, indicate store name and owner of store:

Name of Store \_\_\_\_\_ Owner \_\_\_\_\_

Was the store ever on the WIC Program?  Yes  No

12. Are you (Applicant) related to the previous owner?  Yes  No If yes, what is the relationship: \_\_\_\_\_

13. Have you (Applicant) ever previously applied to participate in the WIC Program and had your application rejected?  Yes  No  
 If yes, when: \_\_\_\_\_

14. Have you (Applicant) ever previously participated in the WIC Program?  Yes  No  
 If yes, specify the date, the previous authorized WIC number (if known), the store name and the state in which store was located  
 (attach a list, if necessary): Date: \_\_\_\_\_ Previous WIC Number: \_\_\_\_\_  
 Name of Store: \_\_\_\_\_ State: \_\_\_\_\_

15. Including this store, have you (Applicant), the corporation or the manager ever owned, managed or been an employee of a firm which received a warning, was disqualified or terminated from the WIC Program?  Yes  No  
 If yes, specify the date, the reason and identify the person(s) or corporation, store name and location involved.

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Store: \_\_\_\_\_ Person(s)/Corporation: \_\_\_\_\_

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

16. Do you (Applicant) own or manage any other grocery or drug stores (in any state) that are currently contracted with WIC?

Yes  No If yes, list the name and address of the store(s). Attach a list, if necessary.

Name of Store \_\_\_\_\_ Address: \_\_\_\_\_

17. Is this store authorized to accept Food Stamps?  Yes  No If yes, Food Stamp Authorization Number: \_\_\_\_\_

a. If no, has Food Stamp Authorization Application been submitted?  Yes  No

b. Has the Food Stamp Authorization Application been rejected?  Yes  No If yes, when: \_\_\_\_\_

18. Including this store, has the Applicant (Owner, the corporation or manager) ever owned or managed a firm which violated the Food Stamp regulations, received a warning letter or was withdrawn, disqualified, assessed a civil money penalty or fined?  Yes  No

If yes, specify the date, the reason, and identify the person(s) or corporation, the store name and location involved.

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Store: \_\_\_\_\_ Person(s)/Corporation: \_\_\_\_\_

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

19. Has the Applicant (Owner, corporation or manager) ever had a license denied, withdrawn, suspended or been fined for license violations (i.e., business or health licenses)?  Yes  No

If yes, list the type of license, the reason for and date of denial, fine, suspension, withdrawal or disqualification.

Type of License: \_\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_\_

20. BUSINESS ETHICS: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager, or 6) any stockholder who has a substantial role in the operation of the store? If yes, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity, and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served, and any other relevant information.  Yes  No

21. List the wholesaler/retailer(s) that you expect to use for the purchase of WIC food items: \_\_\_\_\_

**Infant formula must be purchased from the list of infant formula wholesalers, distributors and retailers licensed in Kentucky or formula manufacturers registered with the FDA. An approved list is available from the State Agency or on-line at <http://chfs.ky.gov/dph/mch/ns/wic.htm>**

22. Indicate the number of cash registers: \_\_\_\_\_ Do any of these cash registers have optical scanners?  Yes  No

If yes, do optical scanners identify WIC approved foods?  Yes  No

23. Is this store open year-round?  Yes  No If no, check the months when the store is OPEN:

- |                                   |                                |                                    |                                   |
|-----------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> January  | <input type="checkbox"/> April | <input type="checkbox"/> July      | <input type="checkbox"/> October  |
| <input type="checkbox"/> February | <input type="checkbox"/> May   | <input type="checkbox"/> August    | <input type="checkbox"/> November |
| <input type="checkbox"/> March    | <input type="checkbox"/> June  | <input type="checkbox"/> September | <input type="checkbox"/> December |

24. Hours of Business:

Monday	_____ A.M.	to	_____ P.M.
Tuesday	_____ A.M.	to	_____ P.M.
Wednesday	_____ A.M.	to	_____ P.M.
Thursday	_____ A.M.	to	_____ P.M.
Friday	_____ A.M.	to	_____ P.M.
Saturday	_____ A.M.	to	_____ P.M.
Sunday	_____ A.M.	to	_____ P.M.

25. List the bank(s) of deposit that will be used for WIC food instruments and the complete address of the bank(s):

Bank \_\_\_\_\_

Branch Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

26. Provide directions to the store from the Health Department in the county where the store is located (Provide highway numbers rather than stating 'Route 1, etc.').

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Is the store name visible on the outside of the store?  Yes  No Indicate name on sign or store front if different than name on the front of this application: \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SUPPLIED BY ME ON THIS APPLICATION AND THE ATTACHED PRICE LIST IS CORRECT. IF IT IS DETERMINED THAT THE INFORMATION SUPPLIED IS NOT CORRECT OR THAT, IN REVIEW OF THE INFORMATION SUPPLIED, THE STATE AGENCY FINDS THAT MY STORE DOES NOT MEET THE CRITERIA TO BE A WIC VENDOR, MY STORE WILL NOT BE APPROVED FOR A CONTRACT. I UNDERSTAND THAT, SHOULD MY STORE BE ACCEPTED FOR A WIC CONTRACT, I WILL BE BOUND BY WIC PROGRAM REGULATIONS AND POLICIES. PRIOR TO THE CONSIDERATION OF THIS APPLICATION, I UNDERSTAND THAT I WILL HAVE TO SUPPLY INFORMATION ON GROSS AND FOOD SALES TO THE STATE AGENCY PRIOR TO AUTHORIZATION AND I MAY BE ASKED FOR FURTHER SALES INFORMATION SUBSEQUENT TO AUTHORIZATION TO ENSURE MY WIC SALES DO NOT EQUAL MORE THAN 50% OF MY YEARLY FOOD SALES. **I UNDERSTAND THAT THIS IS ONLY A REQUEST FOR AUTHORIZATION AND DOES NOT CONSTITUTE A CONTRACT AND I WILL NOT ACCEPT WIC FOOD INSTRUMENTS UNTIL I HAVE RECEIVED AN APPROVED WIC PROGRAM AGREEMENT AND AN AUTHORIZED WIC VENDOR STAMP.** THIS APPLICATION WILL BE A PERMANENT PART OF MY FILE.

\_\_\_\_\_  
AUTHORIZED SIGNATURE (OWNER OR CORPORATE OFFICER ONLY)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TITLE

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**LOCAL AGENCY USE ONLY**

The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applicant has actually taken possession of the store and the property transfer has been completed.

- 1. Review Drug Store's SRP listing(s). (Does/Do) the SRP listing(s) have an extensive list of formula?  Yes  No
- 2. Verify the Price List with the shelf or display case prices, if applicable.
- 3. Is this store primarily a Drug Store?  Yes  No If no, explain:
- 4. **Warn vendor applicant that he/she is not an Authorized WIC Vendor and cannot accept food instruments until the authorized stamp is obtained and initial training completed.**

I CERTIFY THAT I HAVE VISITED THIS STORE AND FIND IT (ELIGIBLE/NOT ELIGIBLE) BASED UPON THE CRITERIA FOR SELECTION OF VENDORS AND THE VENDOR AGREEMENT. IF THIS VENDOR APPLICANT IS NOT ELIGIBLE, PLEASE DOCUMENT WHY:

SIGNATURE OF LOCAL AGENCY REVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

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**STATE AGENCY USE ONLY**

- 1. Food Stamp Number: \_\_\_\_\_ Date Verified: \_\_\_\_\_
- 2. Does the vendor meet the Criteria for Selection of Vendors?  Yes  No  
If no, explain: \_\_\_\_\_
- 3. Recommended for approval?  Yes  No
- 4. Signature \_\_\_\_\_ Date \_\_\_\_\_