



Kentucky WIC Program Retailer/Drug Store Application

Please print unless otherwise indicated.

***All questions on the application must be properly and fully completed.
Please review the Kentucky WIC Manual for Applying Retailers for instructions on
completing this form. Incomplete applications will be denied.***

STORE IDENTIFICATION

1. Store name: _____ Tax ID #: _____

2. Physical address:

Street address/rural route number: _____

City: _____

County: _____ State: _____ Zip: _____

Store telephone number: _____ Fax: _____

E-mail address for store contact: _____

3. Mailing address – complete only if mail cannot be delivered to the physical address.

Street address/rural route number: _____

P.O. Box: _____ City: _____ State: _____ Zip: _____

STORE OWNERSHIP AND MANAGEMENT

4. Type of ownership (check one):

Major Chain – Multiple States

Independent Chain – Local Corporate Ownership

Franchise – Multiple Locations

Franchise – Single Location

Independent – Not a Franchise

Commissary



How many stores are under the same ownership? (Include applying store) _____

How many of these stores are currently authorized for the KY WIC Program? _____

How many of these stores are currently authorized for the Food Stamp Program? _____

5. Corporate Identification - name and address of corporation:

(Parent corp., if store is company owned)

Corporate contact name: _____

Business name: _____

Street number: _____ Street _____

City/State/Zip: _____

E-mail of corporate contact: _____

6. Owner/Corporate Officer:

Owner's/officer's address - enter requested information for owners of sole proprietorships, partnerships, principal shareholders of private corporations, LLC members or officers of a corporation. Include spouses in community property. If more than two owners, attach to this application the same information for each owner:

Present exactly as shown on legal documents.

First and Last Name: _____ Social Security #: _____

Street number: _____ Street/P.O. Box: _____

City/State/Zip: _____ Phone: _____

E-mail address: _____

First and Last Name: _____ Social Security #: _____

Street number: _____ Street/P.O. Box: _____

City/State/Zip: _____ Phone: _____

E-mail address: _____

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 SSNs 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.

7. **Store Manager Identification** - person with primary on-site responsibility for daily operations:

First and last name: _____

E-mail address: _____ Fax #: _____

8. 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?

Yes No

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.

9. Are you (applying owner) related to the previous owner? Yes No

If yes, what is the relationship? _____

10. Have you (applying owner) ever previously applied to participate in the WIC Program and had your application rejected? Yes No

If yes, list date and reason rejected: _____

11. Have you ever previously participated in the WIC Program? Yes No

If yes, name of store: _____ Address: _____

WIC vendor number: _____ Dates of participation: _____

12. Have you, the corporation or the manager ever owned, managed or been an employee of a firm which received a warning, disqualification or termination from the WIC Program? Yes No If yes, list:

Store name and address: _____

Person/entity involved: _____

(Attached a listing of vendor numbers and store names if more than one (1) store.)

Type of action received:

Warning Disqualification Termination Effective date: _____

Reason: _____

13. Previous Store Name and Owner:

Name: _____ Owner: _____

STORE OPERATIONS AND SALES

14. When did (or will) the store open for business under the applying ownership?

Month Day Year

15. What hours is the store open? Example: M – F 7a.m. to 11p.m.; Sat – Sun 7a.m. to 12a.m.

16. Is this store open year-round, AT LEAST 40 hours a week? Yes No

17. Is this store's name visible on the outside of the store? Yes No

If no, indicate name on sign or store front if different than name on the front of this application: _____

18. Indicate the number of cash registers: _____

19. Can this store accept WIC Program benefits electronically? Yes No

This may be done by using the store's own multifunctional equipment or through use of a separate internet access device that transacts only WIC EBT redemptions.

20. Will the store use an FNS certified integrated system? Yes No

21. Does the store have an internet or telephone connection? If yes, what type?

Yes No _____

22. List the internet or telephone service provider for this store. _____

23. Does the store's system have a firewall? Yes No

24. Does the store's system use a dynamic host configuration protocol (DHCP)?

Yes No

25. Does the store's system use static IP addresses? If yes, what are the IP addresses or range of IP addresses? Yes No _____

26. Is there a network or telephone drop/jack near the cash registers?

Yes No If no, indicate the location: _____

27. Please provide technical point of contact for the store:

Contact name: _____ Cell phone: _____

Office phone: _____ Email address: _____

28. Are there additional electrical outlets available in the lane(s)? Yes No

29. Do you expect to derive more than 50% of food sales in WIC? Yes No

30. Is there a valid retail-food establishment or retail food store number in the owner's name? Yes No
 If yes, enter Retail-Food Establishment Number: _____
31. Is this store authorized to accept SNAP? Yes No
 If authorized, enter SNAP authorization number: _____
32. Has this store ever been denied, withdrawn, or disqualified from SNAP?
 Yes No
 If yes, enter date and the reason: _____
33. Has this store ever received a civil money penalty from SNAP? Yes No
 If yes, enter date and the reason: _____
34. Is there a pharmacy located within the confines of the store? Yes No
 If yes, will the pharmacy provide exempt formula or WIC Eligible Nutritionals for the WIC Program? Yes No
35. If applying as a pharmacy, can the store provide exempt formula or WIC Eligible Nutritionals within 48 hours of request? Yes No
36. List supplier from whom WIC foods are purchased:
 Name: _____
 Street number: _____ Street name: _____
 City/State/Zip: _____ Phone: _____
37. List supplier from whom infant formula is purchased. 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>
 Name: _____
 Street number: _____ Street name: _____
 City/State/Zip: _____ Phone: _____

STATEMENTS AND CERTIFICATION

Certification and signature of owners (or person who has the ability to apply on behalf of the store or proxy).

I am applying for authorization for this store to take part in the WIC Program, and I have authority to enter into a WIC vendor agreement.

I understand the prices for the WIC approved foods shall be competitive with and not exceed the average shelf price of other vendors in the same peer group.

I understand that my stock of WIC approved foods must meet the WIC Program requirements for minimum variety and quantity at the time of application as a WIC vendor and throughout the period for which the WIC Vendor Agreement shall be in effect.

I understand that my authorization as a WIC vendor is subject to having a current Retail-Food Establishment or Retail Food Store number and a SNAP number.

I understand that the ownership and management of this store will be responsible for understanding the requirements, policies and procedures of the WIC Program and attending required WIC training.

I certify that 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 this is only a request for authorization and does not constitute a contract, and I will not accept WIC benefits until I have received an approved WIC vendor agreement, an authorized WIC vendor stamp, and a stand beside device (if applicable).

Note: If this is a **cost plus 10% store**, the final price (WIC price) must be posted on the shelf or on signage in aisle.

Note: Only applies to drugstores - I understand that I am to supply only exempt formula or WIC Eligible Nutritionals as requested.

Signature: _____

Date: _____

Print name: _____

Title: _____

USDA Non-Discrimination Statement

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.

This institution is an equal opportunity provider.

LOCAL AGENCY USE ONLY – RETAIL GROCERY

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

1. Complete the following by: (a) checking yes if the store meets both the “inventory specifications” and “total quantity required in stock,” or no if the vendor does not meet the criteria; and (b) checking yes if the store has the prices for food items displayed on the shelf, food item or display case or no if the prices are not clearly displayed.
2. Verify the store’s shelf, item or display case prices match the prices listed on the Approved Items Price List. Yes No If no, explain: _____

FOOD ITEM	INVENTORY SPECIFICATIONS	TOTAL QUANTITY REQUIRED IN STOCK	INVENTORY IN STOCK	COMMENTS	PRICES MARKED
MILK	2 TYPES REQUIRED WHOLE AND 1% (OR LESS) IN GALLON CONTAINERS; MUST SUPPLY ½ GALLONS AND QUARTS UPON REQUEST	4 - GALLONS WHOLE AND 6 - GALLONS 1% OR LESS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CHEESE	1 TYPE REQUIRED MUST BE AVAILABLE IN 8 OUNCE OR 16 OUNCE PACKAGES; NO DELI CHEESE OF ANY TYPE	4 - POUNDS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
EGGS	GRADE A LARGE OR SMALLER	5 - DOZEN	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CEREAL	3 PRODUCTS 2 OF THE 3 PRODUCTS MUST BE WHOLE GRAIN	9 - BOXES	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
JUICE	TWO (2) FLAVORS REQUIRED IN 64 OUNCE CONTAINERS TWO (2) FLAVORS REQUIRED IN 48 OUNCE OR 12 OUNCE FROZEN CONCENTRATE CONTAINERS (RECONSTITUTE TO 48 OUNCES) MUST BE 100 % FRUIT OR VEGETABLES JUICE, UNSWEETENED	COMBINED QUANTITIES TO EQUAL 14 CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

BEANS OR PEAS	1 TYPE DRY BEANS OR PEAS <u>AND</u> 1 TYPE CANNED BEANS OR PEAS	4 - ONE POUND (16 OUNCE) PACKAGES <u>AND</u> 16 - 15 TO 16 OUNCE CANS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
FISH	1 TYPE REQUIRED	45 - OUNCES	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
PEANUT BUTTER	1 TYPE REQUIRED	4 – 16 <u>TO</u> 18 OUNCE CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
WHOLE WHEAT PRODUCTS	1 TYPE REQUIRED	4 - 16 OUNCE LOAVES OF BREAD, TORTILLAS, OR 14 – 16 OUNCE PACKAGES OF RICE	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
FRESH OR FROZEN FRUITS & VEGETABLES	2 TYPES FRESH OR FROZEN FRUITS <u>AND</u> 2 TYPES FRESH OR FROZEN VEGETABLES	10 - POUNDS TOTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT FORMULA	1 TYPE OF CONTRACT BRAND POWDER REQUIRED *GERBER GOOD START GENTLE, GOOD START SOY, GOOD START SOOTHE	11 - CANS TOTAL IN EITHER 12.4, 12.7 OR 12.9 OUNCE CANS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT CEREAL	1 TYPE REQUIRED 8 OUNCE CONTAINERS	3 – 8 OUNCE CONTAINERS TOTAL	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT FRUITS & VEGETABLES	2 TYPES INFANT FRUITS <u>AND</u> 2 TYPES INFANT VEGETABLES	16 – 4 OUNCE 2- PACKS OR 32 - 4 OUNCE CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

*Contract brand and size subject to change. Written notification will be provided.

3. Is this store primarily a retail grocery? Yes No

If no, explain: _____

Indicate staple food items sold at this store (must stock at least two selections in each of the following four staple food groups):

bread/cereal

bread

cereal

pasta

rice

flour

dairy products

milk

cheese

butter

yogurt

other _____

fruits/vegetables

fresh fruits/
vegetables

canned fruits/
vegetables

frozen fruits/
vegetables

100% fruit/
vegetable juices

other _____

meat, poultry, fish

beef/chicken

pork/bacon/ham

eggs

lunch meats/ hot dogs

other _____

Indicate other items sold at this store:

gasoline

lottery tickets

liquor

auto parts

hardware

video rental

deli

bait

4. Have you reviewed with this store the Vendor Agreement and the consequences of Program abuse? Yes No

5. Has the vendor applicant been advised that the store is not an authorized WIC vendor and cannot accept WIC benefits until the certified integrated system or stand beside device is operable.? Yes No

6. Is the retail food permit visible in the store? Yes No

7. 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: _____

Print legibly the name of Local Agency reviewer

Signature of Local Agency reviewer

Date

LOCAL AGENCY USE ONLY – DRUG STORE

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 Suggested Retail Price (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. Advise vendor applicant that the store is not an Authorized WIC Vendor and cannot accept WIC benefits until the certified integrated system or stand beside device is operable and initial training completed.

4. I certify that I have visited this store and find it (**eligible**/ **not eligible**) based upon the criteria for selection of drug stores and the vendor agreement. If this vendor applicant is not eligible, please document why: _____

Print legibly the name of Local Agency reviewer

Signature of Local Agency reviewer

Date

STATE AGENCY USE ONLY

1. Are the food prices competitive? Yes No

2. SNAP Number: _____ Date verified: _____

3. Retail-Food Establishment Number: _____ Date verified: _____

4. Has the fifty percent (50%) criterion assessment been completed? Yes No

5. Does the vendor meet the criteria for selection of vendors? Yes No

If no, explain: _____

6. Has request been sent to CDP for eWIC approval? Yes No

7. Recommended for approval? Yes No

Signature of State Agency reviewer

Date