

RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM NEW RETAIL VENDOR APPLICATION**NEW APPLICANT**

This application is just acceptable for the name(s) and address printed on this label.

Today's Date _____

**Follow these steps prior to returning store application(s):**

Complete & Print all Application(s) in a clear legible manner

- Please **do not use white out** for corrections, simply draw a line over and then write the correct answer
- Sign, notarize and return the **Application(s)** (signature must be of the original contracted WIC person and/or the WIC registered authority only). Signing someone else name is falsification and considered fraud. (See WIC LAW)
- Include a clear, legible & visible **photocopy of the original picture ID** (driver's license, RI Identification) for each one who applies below:
 - ✓ Store owner, President
 - ✓ Legal partner(s)
 - ✓ Corporation officers
 - ✓ Store manager(s)
 - ✓ Pharmacy manager
 - ✓ Person who operates the store when owner is not in
- Include an original **"voided" store check** as part of the Automated Clearinghouse (ACH) Authorization Agreement
- Include a photocopy of your **RI State Sales Tax Permit** for this year and Food Stamp Permit
- Include photocopies of **September & December 2007 and March & June 2008 submitted** to RI State – Division of Taxation **"QUARTERLY RECONCILIATION FOR MONTHLY FILERS"** (T-204 or T-204CIG) reports, Schedule A+B (both sides)
- Include a photocopy of the **active RI Department of Health Food Protection License** (issued annually for each location)
- Include a photocopy of the **"Profit Corporation Annual Report for 2008"** filed with the Rhode Island Secretary of State (if you are a corporation, partnership or LLC)
- Include a **completed and signed WIC Price Sheet** with the store prices
 - ✓ Remember that your prices have to be competitive and they are your responsibility
 - ✓ It is important that you monitor prices and your prices be/remain competitive to qualify and be authorized as a WIC Vendor

All application material must be complete and accurate. Incomplete or inaccurate information could affect the review process and the decision on your application. All applications will be carefully considered and you will receive a written decision on your authorization from the WIC Program. If the application is approved, one original Vendor Participation Agreement will be returned to you.

We appreciate your interest to become a WIC vendor and assist us in providing the best level of service to participating women, infants and children throughout Rhode Island.

If you need more information or have questions on how to complete this application, please contact WIC vendor staff at 401-222-4633, 4630, 4637 or 5930.

Si necesita ayuda en comprender esta carta, por favor, llame al 222-5918 donde le ayudarán con la traducción.

**RHODE ISLAND DEPARTMENT OF HEALTH
WIC PROGRAM
AUTHORIZATION APPLICATION - RETAIL VENDOR**
(Read guidelines before completing this form – this form may not be reproduced)
PLEASE PRINT – white out is not acceptable
Completion of this application does not assure authorization to participate in WIC

STORE NAME AND ADDRESS

Legal Name of Store: _____ Store Telephone # _____
 Legal Name of Pharmacy _____ Pharmacy Telephone # _____
 Name you gave to the Store: _____ FAX # of Store: _____
 Name of Store when you purchased: _____ Date you purchased this store: _____
 Name on Store Signs: _____ E-Mail of Store: _____
 Store Street Address: _____ City: _____ Zip: _____

MAIN OFFICE INFORMATION

Owner's, President's Name: _____ Title: _____
 Contact Persons Name: _____ Title: _____
 Mailing Address/(Main Office): _____ Telephone: (_____) _____
(If different from Store Address)
 City: _____ State: _____ Zip: _____ Fax Number: (_____) _____
 E-Mail Address: _____

STORE INFORMATION

Ownership Type: (check one)

Sole Ownership Commissary Partnership Public Corporation Private Corporation Other: _____
 -Is this store a franchise? Yes No If yes, give name/Address: _____
 -If a corporation, give the corporation ID number from the Secretary of State _____

Store Type:
 Grocery pharmacy
 Grocery & pharmacy other _____

Do you have: Scanners? Yes No # of Registers with scanners
 EBT? Yes No # of Registers with scanners
 Do you scan for WIC items? Yes No # of Registers with scanners

Store Measurements:

Square footage of store	
# of cash registers	
# of cashiers	

Annual Sales:

Food	\$	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></input>
Non-Food	\$	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></input>
Total	\$	<input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/></input>

Do you sell kosher foods? Yes No

Language(s) spoken (beginning with your own natural one): _____

1. Tax Information (is required prior to WIC Approval) RI State Sales Tax Permit # □ □ - □ □ □ □ □ □ □ □ - □ □ □ Federal Employer ID Number (FEIN) □ □ - □ □ □ □ □ □ □ □	2. Food Stamp Authorization (is required prior to WIC Approval) <input type="checkbox"/> Pending Or Authorization Date: ____/____/____ (Required) F. S. # □ □ □ □ □ □ □ □ Owner(s) Name(s) Printed on the Permit: 1. _____ 2. _____ 3. _____
3. Other Licenses License to Sell Lottery Tickets Yes <input type="checkbox"/> No <input type="checkbox"/> # _____ Liquor License Yes <input type="checkbox"/> No <input type="checkbox"/> # _____	4. Health Department License (is required prior to WIC Approval) Health Department License # (From Division of Food Protection) MRK □ □ □ □ □ □ Expiration Date: ____/____/____ Or/and Pharmacy License # □ □ □ □ (If Applicable)

Store/Business Days & Hours:

Open at least 8 hours a Day 6 Days a week Yes No 24 hours

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
OPEN							
CLOSED							

OWNERSHIP

IF SOLE OWNERSHIP (Complete this Section)

Full Legal Owner's Name: ^(circle one) Mr./Mrs./Ms. / /

Home Address: _____

City _____ State _____ Zip Code _____

Home Telephone No: _____ Date of Birth: _____ Social Security No: _____

^(circle one) **Spouse's** Full Legal Name: Mr./Mrs./Ms. / /

Social Security No: _____ Date of Birth: _____

Manager Name (1): ^(circle one) Mr./Mrs./Ms. / /
(and or person who operates store when owner is not at the store) First Name MI Last Name

Home Address: _____

City _____ State _____ Zip Code _____

Home Telephone No: _____ Date of Birth: _____ Social Security No: _____

^(circle one) **Spouse's** Full Legal Name: Mr./Mrs./Ms. / /

Social Security No: _____ Date of Birth: _____

Manager Name (2): Mr./Mrs./Ms. / / Social Security No: _____
First Name MI Last Name

Spouse's Full Legal Name: Mr./Mrs./Ms. / / Social Security No: _____
First Name MI Last Name

IF PARTNERSHIP, COMPLETE THIS SECTION (if more than three partners, attach a separate sheet).

1. Full Legal Partner's Name: ^(circle one) Mr./Mrs./Ms. / / Date of Birth: _____
First Name MI Last Name

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Spouse's Full Legal Name: _____ Social Security No: _____ Date of Birth: _____

2. Full Legal Partner's Name: ^(circle one) Mr./Mrs./Ms. / / Date of Birth: _____
First Name MI Last Name

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Spouse's Full Legal Name: _____ Social Security No: _____ Date of Birth: _____

3. Full Legal Partner's Name: ^(circle one) Mr./Mrs./Ms. / / Date of Birth: _____
First Name MI Last Name

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Spouse's Full Legal Name: _____ Social Security No: _____ Date of Birth: _____

^(circle one)
 Full Legal Name of Manager: Mr./Mrs./Ms. / / Date of Birth: _____
(and/or person who operates the store when owner is not in) First Name MI Last Name

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____

Spouse's Full Legal Name: _____ Social Security No: _____ Date of Birth: _____

IF CORPORATION, COMPLETE THIS SECTION

Remember to include RI Corporate Annual Report (Required Item)

Corporation Full Legal Name: _____ Parent Corporation Name: _____

Corporation Mailing Address: _____ City _____ Zip Code _____

Full Legal Name of President: ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Full Legal Name of Vice President: ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Full Legal Name of Secretary: ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Full Legal Name of Treasurer: ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ No of Shares: _____

Full Legal Name of Manager (1): ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____

Full Legal Name of Manager (2): ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____

Full Legal Name of Pharmacy Manager: ^(circle one) Mr./Mrs./Ms. _____ / _____ / _____ Date of Birth: _____
First MI Last

Home Address: _____ City _____ Zip Code _____

Home Telephone No: _____ Social Security No: _____ Pharmacist License No. _____

OWNERSHIP HISTORY

CRIMINAL CONVICTIONS

Has any owner(s), corporate officer(s), partner(s), representative, manager(s) or other individual who directly or indirectly participates in the operation of the store ever been charged with, or have they ever been convicted of or forfeited collateral for any felony or fraud or misrepresentation in any connection?

Yes No

If YES, give details: _____

WIC, FOOD STAMP AND OTHER LICENSES HISTORY

How many stores does the applicant(s) name appear as part of the ownership and/or management, in Rhode Island and Out of State? _____

List name and Address of each store:

Store Name	Address	City	State	Zip	Is this store Accept WIC?
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 details below: Yes No

Store Name	Address	City	State	Zip	Name
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____
_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____	_____/_____/_____/_____/_____

Has any owner(s), corporate officer(s), partner(s), representative, manager(s) or other individual who directly or indirectly participates in the operation of the store:

- Ever been or is currently disqualified (including civil money penalty or fine) from the Food Stamp or WIC Program? Yes No
- Currently have charges against them for any violation of the rules or regulations of the Food Stamp or WIC Program? Yes No
- Ever received any warnings, notice of administrative charges, sanction, sentence or disqualification for any violation of the rules or regulations of the Food Stamp or WIC Program? Yes No

If YES to any of the above questions, give details for each action below.

Include any past or current (pending) action, even if the individuals in question were employed or connected with a different store at the time of the event, or are not employed or affiliated with a different store. For example, include the situation in which the store's current owner(s)/ manager(s) operate/manage or operated/managed another store at the time it was removed from or sanctioned by the WIC Program in Rhode Island or any other state.

Attach (tape) a permanent blank voided check from your branch's established account for deposit of WIC checks.



WHOLESALE SUPPLIERS

Grocery Primary Wholesaler(s)

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (____) _____ Print Contact Person Name: Mr./Mrs./Ms. _____
Title: _____ Phone Number: (____) _____

Milk Primary Wholesaler

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (____) _____ Print Contact Person Name: Mr./Mrs./Ms. _____
Title: _____ Phone Number: (____) _____

Formulas(s) Primary Manufacturer, Distributor, Wholesaler, Retailers, etc.

- Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Phone Number: (____) _____ Print Contact Person Name: Mr./Mrs./Ms. _____
- Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Phone Number: (____) _____ Print Contact Person Name: Mr./Mrs./Ms. _____

Pharmacy Primary Wholesaler

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (____) _____ Print Contact Person Name: Mr./Mrs./Ms. _____
Title: _____ Phone Number: (____) _____

**Rhode Island Department of Health
WIC Program**

Automated Clearinghouse (ACH) Authorization Agreement

FOR REIMBURSEMENT CREDITS or PAYMENT ADJUSTMENTS AT PEER GROUP MAXIMUM PRICE (ACH CREDITS)
AND PENALTY OR FEE COLLECTION (ACH DEBITS)

This form should be completed (for each store) by either the store owner, partner or the WIC registered authority only

Business Name: _____ Today's Date: _____

Pharmacy Name: _____ Specify, if a different bank accounts: _____

Name on Store Signs (dba): _____ Store Phone No: _____

Store Address: _____ City: _____ Zip Code: _____

Bank report should be mailed to this address: _____

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

Full Legal Owner's (Person's) Name(s): _____
(print)

Full Legal Account Holder's (Person's) Name(s): _____ Title: _____
(print)

Full Legal Account Holder's (Person's) Signature: _____ / _____
(Original Authorized Legal Signature(s))

I (we) hereby authorize and request the RHODE ISLAND DEPARTMENT OF HEALTH - WIC PROGRAM, hereinafter called HEALTH, to initiate and effect Reimbursement or Payment Credit and/or Penalty or Fee Collection entries of any amounts owing by HEALTH to me (us) and any amounts owing by me (us) to HEALTH as such amounts become due by initiating Reimbursement or Payment 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 HEALTH to such account(s) without responsibility for the correctness thereof. Reimbursement or Payment Credit will be initiated if a WIC check is submitted for payment above the current maximum price for my peer group. I agree to accept an adjusted ACH Credit and any related fees if the price on the WIC check(s) submitted for payment exceeds the current maximum price for my peer group. I (we) (the signor above) certify that I have the legal authority to sign this agreement.

ANY MODIFICATION TO ACCOUNT INFORMATION MUST BE REPORTED IMMEDIATELY

Depository Bank Name: _____

City: _____ State: _____ Zip: _____

Routing Number _____ Account Number _____

Pharmacy Bank If different than Grocery _____ RN# _____ Acct # _____

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

I (we) with the above signature, certify that all the above information is true. I (we) 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 permanent disqualification, denial and/or termination from the WIC Program up to six 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.

Deleted: ¶

AFFIDAVIT OF APPLICANT

(Must be completed by the storeowner, partner or corporate officer or other individual who has the WIC registered authorization to sign this application on behalf of the vendor.)

Full Legal Name of Applicant Completing This Affidavit (Print)

Title

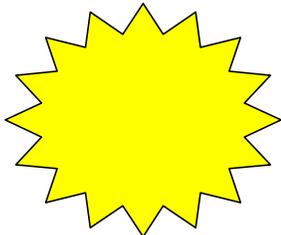
I CERTIFY THAT

1. All information submitted on this application and any supporting documents are accurate and complete.
2. I understand that Rhode Island Department of Health (HEALTH) -WIC Program (WIC) officials may verify any information relating to this application.
3. I understand that there is a limited number of vendor openings and that this application does not guarantee selection and authorization to participate in HEALTH WIC.
4. I understand that I may not accept WIC checks until authorized by HEALTH WIC.
5. I am applying for authorization to take part in HEALTH WIC. If my application is approved by HEALTH WIC, I agree to abide by applicable HEALTH rules and regulations, including but not limited to *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health (R42-35-PP)* as set forth in Chapter 42-35 and Chapter 38-2 of the General Laws of Rhode Island, as amended, policies and procedures as stated in the application form, the contract agreement, the WIC Vendor Policies, federal regulations, and other applicable rules, states, and regulations and further agree to comply with subsequent amendments or updates.
6. I understand that the HEALTH WIC contract may be terminated and the WIC stamp must be returned if a change or modification of ownership occurs and agree to notify HEALTH WIC of a change or modification of ownership.
7. I understand that if I become above 50% vendor, I am required to lower the prices to maintain WIC authorization.
8. I agree that my business, including all employees, will comply with HEALTH WIC rules and regulations, procedures and guidelines as referenced in #5 and understand that HEALTH WIC may revoke my authorization to participate if there is noncompliance committed by myself, by any of the business' employees or representative.
9. I agree to cooperate with periodic on-site monitoring by HEALTH WIC vendor monitoring officials.
10. I understand that I (and other store staff) will be required to attend HEALTH WIC training sessions and that I am required to train store employees regarding HEALTH WIC rules and regulations, procedures and guidelines.
11. I understand that I must submit accurate price lists of HEALTH WIC authorized foods at least once per year or upon request.
12. I understand that this application becomes part of the subsequent HEALTH WIC Vendor Participation Agreement, if approved.
13. I understand that HEALTH WIC may revoke my authorization to participate if there is noncompliance committed by myself, by any of the business' employees or representatives.

I, the above-named applicant state that I am the person referred to in this application as the owner, partner, or corporate officer of the store indicated on the Rhode Island WIC Program Retail Vendor Application or that I have the WIC registered authority to sign this application on behalf of the vendor, and that all the statements herein contained are each and all true in every respect. I understand that false statements made in connection with this application may be grounds for denial of the application or termination of the location as an authorized HEALTH WIC Vendor.

ORIGINAL SIGNATURE OF APPLICANT _____ Date Signed _____

Subscribed and sworn to before me this _____ day of _____, 20_____.



Notary Public (Print Name): _____

NOTE: As this person's notary you are certifying that this signature is the original and authentic signature of the business owner who is completing this application form to obtain a WIC Vendor Agreement. Notaries are covered under the WIC Law and Regulations associated with any violations that may occur with this application process.

Notary Public Original Signature _____

Commission Expiration Date _____

As a notary you must request two forms of recent photo identification with their signature and must attach a clear, visible and legible copy to this application.

One must be his/her Driver's License or Rhode Island State Identification, and Passport ID or Other: Give details _____

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer. For sex or handicap complaints, contact the State Equal Opportunity Office, One Capitol Hill, Providence, RI 02908."

WIC VENDOR BULLETIN
Office of Women, Infants and Children (WIC)
Ann Barone, Chief



REMINDER
WIC Antifraud Law

WIC will disqualify and/or penalize any vendor, participant, or applicant whose signature on documents has been altered, falsified, or signed by another person.

This is to remind you that you cannot sign any document with another person's name. This is considered falsification and is covered under the WIC Antifraud Law which says:

“This act would establish criminal fines against WIC Program vendor, clients, staff or others who defraud or abuse the WIC Program through concealment, theft, misapplication or fraudulent obtaining of WIC funds or WIC vendor identifier.”

The penalty for fraud, abuse, and deception is a fine of \$10,000 if the crime incurs a loss of \$500 or more, or \$1,000 if the crime incurs a loss of less than \$500.

Examples of falsification:

- Signing any document with another person's name and presenting it to WIC;
- Misrepresentation by anyone as an authorized WIC vendor is punishable by a fine of \$10,000 if there is transaction of WIC checks, or a \$1,000 penalty there is no evidence of WIC check transactions,
- Unauthorized possession or use of a WIC vendor identifier (Vendor Stamp) brings a penalty of \$10,000 if the Stamp has been used in the transaction of WIC checks, or a penalty of \$1,000 if the Stamp has not been used in the transaction of WIC checks.

Any penalty imposed under the ACT is in addition to repayment of any claims and in addition to any other sanctions or penalties as set forth in WIC Program rules.

We believe that the vast majority of WIC vendors are honest, hard working, and try to provide good value and service to the Program and its clients. This Act's intent is to discourage abuse of the WIC Program among a small group who try to fraudulently profit. They reduce Program funds going to those in need.

If you have any questions or concerns, please call the Vendor Unit in the WIC State Office at 222-4630, 222-4637, or 222-4633.

Si necesita ayuda en extender esta carta, por favor, llame al 222-5918 donde le ayudarán con la traducción.

