District of Columbia
Department of Health
Nutrition and Physical Fitness Bureau
WIC PROGRAM

Vendor Application

(Please complete each line. Type or print legibly)

BACKGROUND INFORMATION

1. Legal name of store _____

2. Trade name of store _____

3. Address of Corporate Office _____

4. Mailing address (if different from No. 3) _____

5. The legal structure of this business is:

☐ Single Proprietorship: one that owns or holds exclusive legal rights; privately owned and managed and run as a profit-making organization rights

☐ Partnership: a legal relationship existing between two or more persons contractually associated as joint principals in a business

☐ Corporation: a group of merchants or traders united in a trade guild

☐ Specialty: _____

6. Name of Owner(s). If a Corporation, name of Officer(s) who's legally responsible

_____	_____
Name	Name
_____	_____
Address	Address
Telephone _____	Telephone _____
Fax _____	Fax _____
E-mail _____	E-mail _____

7. Specify the name of the person or company representative who is fiscally responsible.

_____	_____
Name and Title	Address

8. The number of store(s) owned by this business in the District of Columbia and Prince Georges County, Maryland is _____

9. How many of these store(s) currently participate in the WIC Program? _____

10. Numbers of stores applying for participation under this application. _____
(Note: See Attachment A)

11. The type of operation of store(s) may be categorized as:

☐ Independent ☐ Franchise ☐ Chain ☐ Co-op ☐ Other

If other, please describe _____

_____

_____

12. Provide the following for the chain/store if applicable:

a) Duns # _____Federal I.D.# _____

b) Bank Name: _____ Bank Account # _____

c) Bank Routing # _____

d) Name of your Authorized Wholesaler, Distributor or Retailers registered with the Food and Drug Administration (FDA) from which you shall purchase infant formula.

Name: _____ Phone # _____

Email Address: _____

Name: _____ Phone # _____

Email Address: _____

e) Corporate Warehouse Contact for standard infant formula(s):

Name: _____ Phone # _____

Email Address: _____

f) Name of contact person who will be responsible for submitting the monthly Commodity Price Listing (CPL) to the State Agency.

Name: _____ Phone # _____

Email Address: _____

13. Do you expect to receive more than 50 percent of your annual revenue from the sale of WIC food items? ☐ yes ☐ no

TRAINING INFORMATION

14. Specify the name of the person who will be responsible for training store personnel on WIC procedures and communicating program changes to store cashiers.

Store Training Representatives (**Corporate Level)**

Name: _____
Title: _____
Address: _____
Telephone: _____
Fax: _____
E-Mail Address: _____

DECLARATION OF INTENT

I hereby apply to participate in the D.C. WIC Program. To the best of my knowledge this store qualifies to be an authorized WIC vendor.

I assert that all of the statements in this application are true and I understand that false statements made herein may result in the denial or withdrawal of approval to participate in the program. Any changes in this information must be communicated to the WIC State Agency immediately.

I am aware that the WIC Program is an equal opportunity Program and that I may not discriminate on the basis of race, color, religion, national origin, age, sex, handicap, marital status, personal appearance, sexual orientation, family responsibilities, matriculation or political affiliation.

I certify that all applicant stores will cooperate with D.C. WIC Program and USDA staff in the performance of:

a. Unannounced and announced on-site monitoring visits and;
b. Ensure that appropriate staff attends annual and other vendor training sessions.

_____

(Signature of Store Owner or Representatives and Title)

USDA Nondiscrimination 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.

Attachment A: Store Specific Data

1) Provide response to the following questions for each store covered by this application.	Store _____ Phone _____ Address_____ Fax _____ City _____ State _____ Zip_____ D.C. Ward# _____ ☐ New Applicant	Store _____ Phone _____ Address_____ Fax _____ City _____ State _____ Zip_____ D.C. Ward# _____ ☐ New Applicant
2) How would you best describe the applicant store?	☐ Supermarket ☐ Delicatessen ☐ Small grocery store ☐ Pharmacy ☐ Convenience Store ☐ Other, specify, _____	☐ Supermarket ☐ Delicatessen ☐ Small grocery store ☐ Pharmacy ☐ Convenience Store ☐ Other, specify, _____
3) Name of Store Manager or other person responsible for WIC at the applicant store.	Title _____ Name _____	Title _____ Name _____
4) Days and hours of operation. (If the applicant store is a pharmacy, give the specific pharmacy hours of operation.)	Days Hours _____ to _____ am to _____ pm _____ to _____ am to _____ pm	Days Hours _____ to _____ am to _____ pm _____ to _____ am to _____ pm
6) Total square footage of store.	_____ Square feet	_____ Square feet
7) Total number of cash registers in store/pharmacy.	_____ Cash registers	_____ Cash registers

Attachment A: Store Specific Data

9) What was the stores annual food sales in 2015 (Jan. 1st – Dec. 31st.)?	$ _____	$ _____
10) Does the applicant store participate in the DC/MD Supplemental Nutrition Assistance Program (SNAP)? If yes, please indicate length of time.	☐ Yes ☐ No Dates of Participation: ____/____/____ to ____/_____/_____ SNAP Authorization Number_____	☐ Yes ☐ No Dates of Participation: ____/____/____ to ____/_____/_____ SNAP Authorization Number_____
11) Has the applicant store ever been disqualified from WIC or the SNAP?	☐ Yes ☐ No	☐ Yes ☐ No
12) Has the applicant store received a civil money penalty due to WIC or SNAP violations? If yes, please explain.	Comments	Comments