**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-40034 (10/2022)

**STATE OF WISCONSIN**
Wis Stats. § 253.06(3)
Wis. Admin. Code ch. DHS 149.06
(608) 266-6912

# RETAIL VENDOR INITIAL AUTHORIZATION APPLICATION
# WISCONSIN WIC PROGRAM

| **OFFICE USE ONLY** | Date Received | Tracking Number | Project Number | Vendor Number |
|---|---|---|---|---|
| | | | | |

Completion of this form is required for authorization as a WIC vendor pursuant to 7 CFR 246.12, Wis. Stats § 253.06(3), and Wis. Admin. Code DHS Chapter 149.06. The submission of this application does not guarantee WIC vendor authorization. Information on the application (including your Social Security number) will be used to determine eligibility or continuing eligibility for WIC authorization and may be disclosed to federal, state, and local law enforcement agencies and federal and state tax authorities for the purposes of eligibility determination, law enforcement, forfeiture assessments, forfeitures, and recoupments. Provision of Social Security numbers is optional; however, failure to provide this information may increase the time it takes to process your application. Access to your Social Security number within the Department shall be limited to personnel who need to know this information as part of their job duties.

## ► 1. STORE INFORMATION

| | | | | |
|---|---|---|---|---|
| Name Store Is Doing Business As (DBA) | Legal Name of Store | | | |
| Store Telephone | Cell Phone | Company Email Address | | |
| Store Type (check one)<br>☐ Grocery ☐ Pharmacy | # Of Staffed Cash Registers | # Of Self-Checkout Cash Registers | | |
| Street Address of Store | City | State | Zip Code | County |
| Store Mailing Address | City | State | Zip Code | County |
| Is Store Able to Receive US Mail?<br>☐ Yes ☐ No | | | | |

## ► 2. OWNERSHIP TYPE Check one. Go to www.wdfi.org for definitions of ownership types. If your business is a corporation or partnership, it must be registered with the Department of Financial Institutions (DFI) and remain in good standing.

| | | |
|---|---|---|
| ☐ Sole Proprietor | ☐ Limited Liability Company (LLC) | ☐ Limited Liability Partnership (LLP) |
| ☐ Corporation | ☐ Limited Partnership (LP) | ☐ Partnership |
| ☐ Other | | |

## ► 3. COMPANY INFORMATION

| | | | |
|---|---|---|---|
| Federal Employer Identification Number (FEIN) | DFI (Department of Financial Institutions) Entity ID (n/a for sole proprietors) | | |
| Street Address and/or PO Box | City | State | Zip Code |
| Company Phone | Company Fax | Person WIC Should Contact | |
| Contact Person's Title | Contact Person's Cell Phone | Contact Person's Email Address | |

## ► 4. STORE INFORMATION

| | |
|---|---|
| Store size in square feet (not including living areas or space used for other purposes) | Wisconsin Seller's Permit Number |

## ► 5. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) AUTHORIZATION INFORMATION Please provide this information if your store is authorized for SNAP or has applied for authorization.

| | | |
|---|---|---|
| SNAP Authorization Number | Date Authorized | Date Applied (if not authorized) |
| | | |

**► 6. INFANT FORMULA SUPPLIER INFORMATION** Provide the name and location of each source providing WIC-approved infant formula to your business. If you purchase infant formula from more than four sources, attach a separate page listing the name, address, and telephone number of each.

| Supplier Name | Street Address | City | State | Zip Code | Phone |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**► 7. ELECTRONIC CASH REGISTER (ECR)/POINT-OF-SALES (POS) SYSTEM**

Does the store have an electronic cash register and point-of-sale (ECR/POS) system that is *eWIC*-capable? ☐ Yes ☐ No
If **YES**, complete Section 7a. If **NO**, skip to Section 7b.

**7a. Store is using an ECR/POS cash register system**

| | |
|---|---|
| Cash Register System Provider (i.e., RDS, NCBP, proprietary system) | Software Name and Version |
| Cash Register System Provider Contact Person | Contact Person's Telephone (include area code) |
| Contact Person's Email Address | Who is your Third-Party Processor?<br>☐ World Pay ☐ FIServ |

**7b. Store is *NOT* using an ECR/POS cash register system**

Does your store currently process debit/credit on a stand-alone device? If **YES**, answer the rest of the questions in this section.
☐ Yes ☐ No

| | |
|---|---|
| Does your store currently process SNAP on this same debit/credit device?<br>☐ Yes ☐ No | Do you own or lease the device?<br>☐ Own ☐ Lease |
| Provide the name of the company that provides the stand-alone device. | Company Phone (include area code) |

| | | |
|---|---|---|
| Does your store currently have high-speed internet connection?<br>☐ Yes ☐ No | If **YES**, list internet provider: | If **NO**, does the store use a phone line to connect to the device?<br>☐ Yes ☐ No |

**► 8. STORE HOURS**

Is this store open at least 40 hours per week?
☐ Yes ☐ No

Is the store open 24 hours per day?
☐ Yes ☐ No If **NO**, fill in the hours below.

| Day | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| **Time Open** | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM |
| **Time Closed** | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM |

**► 9. BANKING INFORMATION**

| Bank Name and Branch | Routing Number | Account Number | Phone |
|---|---|---|---|
| Address | City | State | Zip Code |

## ► 10. STORE HISTORY

| When did the store open or is scheduled to open under the applicant's ownership? | Was there a business at this location prior to the applicant's ownership or is there currently? ☐ Yes ☐ No<br>If **YES**, complete the next two lines. |
|---|---|
| Business Name | Name of Previous Owner |
| Was the business WIC authorized?<br>☐ Yes ☐ No | Date of change of ownership or last known date store was open |

Does the applicant or any of the owners, managers, or employees have any relationship with the previous owner(s)? Relationship includes, but is not limited to: partner, shareholder, stockholder, member, immediate or extended family member, corporate officer, manager, employee, or other type of relationship.

☐ Yes ☐ No If **YES**, complete the next line. If more space is needed, submit the information on a separate page.

| Name | Describe the relationship to the previous owner |
|---|---|

Has the applicant or any of the managers currently or previously participated in the WIC Program as an authorized vendor?

☐ Yes ☐ No If **YES**, list the store information below or on a separate page and submit with the application.

| Store Name | Street Address, City, State, Zip | Vendor Number | Authorization Dates |
|---|---|---|---|
| | | | From: To: |
| | | | From: To: |
| | | | From: To: |

Do you own the **BUILDING** or rent/lease the building space? ☐ Own ☐ Rent/Lease
If you own the building, submit a copy of proof of ownership with the application. If the space is leased, submit a copy of the lease agreement with the application. Provide the following lessor (landlord) information:

| Lessor Name | Lessor's Street Address, City, State, Zip Code |
|---|---|

Do you own or lease the **BUSINESS**? ☐ Own ☐ Lease
If you own the business, submit a copy of proof of ownership with this application. If the business is leased, submit a copy of the lease with the application, and provide the following lessor (landlord) information.

| Lessor Name | Lessor's Street Address, City, State, Zip Code |
|---|---|

## ► 11. OWNERSHIP/MEMBERSHIP List all owners, agents, corporate officers, and members. If there are more owners/members than the space provided, submit the information on a separate page. If owner is also a manager, enter his/her information below in section 12.

| 1. Name (First, Middle, Last) | | Title | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| SSN | Percent of Ownership | Home Address | |
| 2. Name (First, Middle, Last) | | Title | Date of Birth (MM/DD/YYYY) |
| SSN | Percent of Ownership | Home Address | |
| 3. Name (First, Middle, Last) | | Title | Date of Birth (MM/DD/YYYY) |
| SSN | Percent of Ownership | Home Address | |

## ► 12. STORE MANAGERS Provide names exactly as shown on legal documents.

| Name (First, Middle, Last) | Social Security Number | Date Of Birth (MM/DD/YYYY) | Business Email |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

► **13. SALES INFORMATION** In accordance with Wis. Admin. Code § DHS 149.05(10), the Wisconsin WIC Program is required to evaluate annual food sales and the amount of revenue that is expected to come from WIC and other sources. All food sales information requested below is based on the sale of SNAP-eligible items. See the Food Sales Fact Sheet (P-00295) for additional information on which foods are SNAP-eligible.

● ANNUAL GROSS SALES

Provide total of all food and non-food sales for the last tax year or the most recent twelve-month period. If the store has been open less than one year, provide an estimate of annual sales. $ _____

● TOTAL FOOD SALES

A. If the store has been in business **for less than one year** at the time of application, estimate the anticipated annual food sales. Attach available Wisconsin Sales and Use Tax Forms (Form ST-12). $ _____

B. If the store has been in business **for one year or more**, list the actual food sales for the past year. Provide copies of your Wisconsin Sales and Use Tax Forms (Form ST-12) from the most recent quarter. $ _____

C. Provide last month's total food sales. $ _____

● WIC SALES

Do you expect WIC sales to be more than 50% of your total annual food sales revenue? ☐ Yes ☐ No

● PERCENT OF FOOD SALES

Please estimate the percent of annual food sales for each category.

_____% SNAP

_____% WIC

_____% Cash, Credit, Debit

► **14. FINES, DISQUALIFICATIONS AND CONVICTIONS** Have any of the owners, owners' spouses, representatives, agents, managers, employees, or anyone else who directly or indirectly participates in the operation of the grocery store/pharmacy:

A. Been disqualified, fined, assessed a civil money penalty (CMP), or denied application by the WIC or SNAP programs in WI or another state?
☐ No ☐ Yes If **YES**, for each action, provide the store name, store address, type of action and dates of action.

B. Accrued any unsatisfied fines (i.e., repayments, CMPs, forfeitures, enforcement penalties) owed to the WIC or SNAP programs in WI or another state?
☐ No ☐ Yes If **YES**, for each action, provide the store name, store address, type of action and dates of action.

C. Been charged with or convicted of a crime or a civil judgment (including tax warrants) entered against them in the last six years in WI or another state?
☐ No ☐ Yes If **YES**, list all state and federal charges or convictions, including individual's name, date of birth, type of offense, date, city, and state.

► **15. OWNER(S)/FAMILY RECEIVING WIC OR SNAP** If any of the owners, owners' spouses, managers, or their minor children are currently receiving WIC and/or SNAP benefits**,** provide their names and social security number and indicate the types of benefits the person(s) is receiving. Use a separate page and attach if more names than spaces provided.

| Name | Social Security Number | Benefit Type(s) |
|---|---|---|
| | | |
| | | |
| | | |

**A complete application must have all required names and signatures, and it must be notarized.**
**If any of these are missing, the application will not be considered complete and will be returned to the applicant.**

► **16. IDENTIFICATION OF PERSON COMPLETING APPLICATION**

| Name of Individual Completing Application (Print or Type) | Title (Print or Type) |
|---|---|
| **Signature** — Individual Completing Application | Date Signed (MM/DD/YYYY) |

► **17. AFFIDAVIT OF APPLICANT** Must be completed by the storeowner, partner, corporate officer, or other individual who has authorization to sign on behalf of the vendor.

- I have legal authority to sign this agreement as an applicant seeking to become authorized as a WIC vendor.
- I have read the application, vendor agreement, and the state regulations provided to me, which includes the conditions of participation set forth in DHS 149 Wis. Admin. Code. I agree to comply with the requirements set forth in the application and state and federal regulations and with any changes in program requirements or regulations made during the agreement period.
- I assert that all the statements in this application are true. I understand that false statements made herein will result in the denial of authorization to participate in the WIC Program or rescission of the authorization should the information be found to be false after the store has been approved for authorization.

| Full Legal Name of Applicant Completing Affidavit (Print or Type) | Title (Print or Type) |
|---|---|
| **Signature** — Applicant | Date Signed (MM/DD/YYYY) |

**WARNING! Information in this application may be verified with other agencies.**
**WIC vendor authorization will be denied or terminated if false information is provided on this application.**