NEW VENDOR REQUEST (Revised October 2020)
OSDH WIC Service

WIC Vendor# _____
(Pending)

State Office use only
Region_____, Class_____, Peer Group_____

1. Store Name_____

Store Phone_____ FAX Number_____ E-mail (Required)_____

Store Address_____
(if rural location include map with directions)

City_____ County_____ Zip_____

Mailing Address:_____ City_____ Zip_____

Manager Name_____ WIC Contact Name_____

Primary Grocery Supplier/Wholesaler Name _____ Shipping Location_____

Milk Supplier/Wholesaler Name _____Shipping Location_____

Licensed Formula Supplier/Wholesaler Name _____ Shipping Location_____

Date opened/acquired by owner: _____/_____/_____

Circle Days Closed: SUN MON TUES WED THURS FRI SAT Hours of operation _____

Employer ID Number (FEIN) _____ SNAP ID# _____

State Sales Tax #_____ Health Department Sanitation Permit #_____

Does the owner own any other retail food outlets? Yes_____ No_____
(if yes, attach a listing including store names and locations to this form)

Does the owner have/had agreements(s) with any other WIC program(s)? Yes_____ No_____

(if yes list the program(s) _____)

Does the owner expect to derive more than 50 percent of its annual revenue from eWIC sales? Yes_____ No_____

Does the store location have internet access through DSL or Broadband? Yes_____ No_____

(if yes list the service provider _____)

Who is your Third Part Processor (TPP)? _____

Processor Contact Name: _____ Contact Telephone: _____

Who is your Point of Sale (POS) service provider: _____

Provider Contact Name: _____ Contact telephone: _____

2. Please answer the following questions based on actual sales and current store setup.
(New businesses provide estimates sales figures.)

A. Gross Sales Last Year $_____

B. Staple Food Sales Last Year $_____

C. Non-Food Sales (tobacco/paper/cleaners/pet foods, etc.) $_____

D. Beer/Hot Foods/Motor Fuel Sales Last Year $_____

E. Retail Sq. Ft._____ Number of check-out lanes: Regular:_____ Express:_____

F. Scan Registers Yes_____ No_____ (If Yes are the WIC Food Items Programmed in the computer as WIC Approved Yes_____ No_____

G. In store pharmacy Yes_____ No_____ Leased_____ Owned_____

H. During the past six years, has any current owner, officer, or manager at your store been convicted of or had a civil judgment for any of the following activities: Fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, receiving stolen property, making false claims, or obstruction of justice. YES_____NO_____ (If so, please specify the name of the owner, officer, or manager and the activities involved.)

_____

_____

_____

I. Have you ever been sanctioned or terminated by the Supplemental Nutrition Assistance Program (SNAP) or any other WIC Program? YES_____NO_____(if yes attach a listing of which program and the reason for the action.)

3. Please answer the following questions based on which vendor type your store is (ie: Partnership, Corporation or Sole Proprietor).

A. Partnership Name: _____ Phone #_____

Officers/Partners Name: _____ SSN_____/____/_____
(List All)

_____ SSN_____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Number of Non-WIC Stores Owned: _____ Number of WIC Stores Owned: _____

B. Corporation Name: _____ Phone #_____

Corporate/General Office Address: _____ City: _____ State: ___ Zip: _____

Officers Name &Titles: _____ SSN_____/____/_____

_____ SSN_____/____/_____

_____ SSN_____/____/_____

Number of Non-WIC Stores Owned: _____ Number of WIC Stores Owned: _____

C. Sole Proprietor Name: _____ SSN_____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Number of Non-WIC Stores Owned: _____ Number of WIC Stores Owned: _____

Participant Distribution and Number of Vendors:

- **Upon receipt of the completed application, the department shall utilize participant/vendor ratios and shall consider participant needs within geographical locations to determine if the applicant meets the county participant/vendor ratio.**

Competitive Pricing:

- **The vendor/applicants price list for the WIC Authorized Foods will be analyzed to determine competitiveness of prices. (Competitive prices are established using eWIC benefit redemptions by vendors currently under agreement with the OSDH/WIC Program within the applicants' geographical area).**

STATEMENT OF APPLICATION
(return with signed/notarized agreement)

1. The applicant has reviewed the WIC Vendor Handbook. The Handbook may be reviewed at https://drive.google.com/drive/folders/1EeM_6EWdzPtsGDdpMIHYHlVg_24hm8wg?usp=sharing

   _____YES _____NO

2. The applicant has reviewed and understands the policies and procedures of the program with respect to vendors.
   _____YES _____NO

3. The applicant asserts that he/she and all employees will comply with the program regulations and understands that authorization to participate in the program may be terminated for violations of program regulations by he/she and employees.
   _____YES _____NO

4. The applicant understands that vendors who violate WIC Regulations risk losing their food stamp authorization per Section 278.1 (o). Further, a vendors previous non-compliance with WIC policy and/or procedures will be considered when renewing the agreement with the vendor and may be used as criteria in determining whether the vendor is eligible for renewal.
   _____YES _____NO

5. The applicant agrees to update any of the information on the application/price list as requested by the program.
   _____YES _____NO

6. The applicant understands that his/her price list will be analyzed to determine competitiveness of prices. (see page A-3 WIC Vendor Handbook)
   _____YES _____NO

7. The applicant understands that the State reserves the right to terminate a vendor whose WIC program business is insufficient to warrant continued participation.
   _____YES _____NO

8. The applicant understands that each vendor site listed in the application shall have seventy percent (70%) or more gross receipts from the sale of non-alcoholic products and gasoline.
   _____YES _____NO

9. The applicant requests authorization to participate in the Special Supplemental Food Program for Women, Infants and Children (WIC)
   _____YES _____NO

ALL AREAS OF THIS APPLICATION AND PRICE LIST MUST BE COMPLETED

The undersigned asserts that all of the statements and information provided herein and on the accompanying price list are true and accurate, and understands that false information may result in the denial or withdrawal of approval to participate in the Oklahoma WIC Program.

SIGNATURE:
Owner/Manager_____Date_____

Note: This application does not constitute an agreement.