TENNESSEE DEPARTMENT OF HEALTH
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
FOR WOMEN, INFANTS, AND CHILDREN

2022 - 2024 PHARMACY APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE TENNESSEE WIC PROGRAM	**FOR WIC USE ONLY** REG _____ CO _____ VENDOR NO _____ Peer Group _____ Owner ID: Y N Sanitation Score _____ Date _____ Vendor Rep _____ Date Received _____(MM/DD/YYYY) Date Approved _____(MM/DD/YYYY)

Follow instructions and review prior to submitting to WIC Regional Office. ***Complete in ink or type.***
Only completed applications, including required attachments, will be processed.
However, submission of a completed application does not guarantee authorization.

PART I. STORE IDENTIFICATION

1. **STORE NAME** _____

2. **TENNESSEE SALES TAX NUMBER** _____ **BUSINESS LICENSE NUMBER** _____

3. **FOOD STAMP (SNAP) AUTHORIZATION NUMBER** _____ ☐ NOT SNAP AUTHORIZED

NOTE: PHARMACY APPLICANTS SNAP AUTHROIZED OR APPLICANTS WHO WERE PREVIOUSLY DISQUALIFIED OR ISSUED A CIVIL MONEY PENALTY SHALL PROVIDE AND ATTACH A COPY OF THEIR SNAP AUTHORIZATION

4. **SQUARE FOOTAGE OF STORE** _____sq ft.

___ Extra Small (< 3,000 sq ft.) ___ Small (3,001—5,000 sq ft.) ___ Medium (5,001—10,000 sq ft.)
___ Medium Large (10,001—50,000 sq ft.) ___ Large (50,001—100,000 sq ft.) ___ Extra Large (>100,000 sq ft.)

5. **STORE LOCATION**

A. PHYSICAL ADDRESS— DO NOT PUT POST OFFICE BOX NUMBER

Street Address / Rural Route Number _____

City _____ State _____ Zip _____

County _____ Telephone (_____)_____ Fax (_____)_____

E-mail Address for Physical Location (Preferred): _____

Additional E-mail Address (Personal or Corporate Contact): _____

B. MAILING ADDRESS—COMPLETE ONLY IF MAIL CAN NOT BE DELIVERED TO PHYSICAL LOCATION

Address / Post Office Box _____

Office / Apartment / Suite Number _____

City _____ State _____ Zip _____

6. **DATE STORE OPENED (OR WILL OPEN) UNDER CURRENT OWNERSHIP?** _____(MM/DD/YYYY)

7. **INDICATE TOTAL NUMBER OF STORE'S REGISTERS, CHECKERS, AND SCANNERS**

Registers _____ # Checkers _____ # Scanners _____ Are scanners WIC Programmable? ☐ Yes ☐ No

8. **INDICATE VALUE ADDED RESELLER (VAR) AND FRONT END (CASH REGISTER) SOFTWARE**

VAR _____ FRONT END SOFTWARE _____

PART II. STORE OWNERSHIP AND MANAGEMENT

9. **TYPE OF OWNERSHIP—**Check one type:

__ Sole Proprietorship __ Corporation (Private or Public) __ Partnership __ Incorporated

__ Cooperative __ Limited Liability Corporation __ Government-Owned

__ Other. Please specify: _____

10. **OWNERSHIP IDENTIFICATION**

A. INDICATE COMPANY NAME OR INDIVIDUAL OWNER NAME

Company Name _____

Owner First Name _____ MI _____ Last Name _____

B. OWNERSHIP EFFECTIVE DATE? _____ (MM/DD/YYYY)

C. PHYSICAL ADDRESS— DO NOT PUT POST OFFICE BOX NUMBER

Street Address / Rural Route Number _____

City _____ State _____ Zip _____

County _____ Telephone (_____)_____ Fax (_____)_____

E-mail Address: _____

D. MAILING ADDRESS—COMPLETE ONLY IF MAIL CAN NOT BE DELIVERED TO PHYSICAL LOCATION

Address / Post Office Box _____

Office / Apartment / Suite Number _____

City _____ State _____ Zip _____

E. LIST OTHER OWNER STAFF OR OFFICERS— Check box if individual is a signatory

First Name _____ Last Name _____ Title _____ Signatory? ☐

First Name _____ Last Name _____ Title _____ Signatory? ☐

First Name _____ Last Name _____ Title _____ Signatory? ☐

F. HOW MANY STORES OPERATE UNDER THIS OWNERSHIP? (Include applying store) _____

G. IN HOW MANY STATES DOES THIS OWNERSHIP OPERATE ALL STORES?

☐ Tennessee Only ☐ 2 - 29 States ☐ ≥ 30 States

11. **NUMBER OF STORES CURRENTLY AUTHORIZED** (Include applying store if currently authorized)

For the Tennessee WIC Program? _____ For another WIC Program? _____

**** PRESENT NAME EXACTLY AS SHOWN ON LEGAL DOCUMENTS INCLUDING THOSE PRESENTED TO THE WIC PROGRAM. GOVERNMENT ISSUED PHOTO IDENTIFICATION (I.D.) MAY BE REQUIRED.****

12. VENDOR STAFF IDENTIFICATION — Provide full name and contact information (telephone and/or e-mail) for following vendor staff (if applicable)

Store Manager: _____ E-mail _____

Address _____ ☐ Same as Store Address ☐ Same as Store Mailing

City _____ State _____ Zip _____

Telephone: (_____)_____ Fax: (_____)_____

District Manager: _____ E-mail _____

Address _____ ☐ Same as Store Address ☐ Same as Store Mailing

City _____ State _____ Zip _____

Telephone: (_____)_____ Fax: (_____)_____

Store Representative: _____ E-mail _____

Address _____ ☐ Same as Store Address ☐ Same as Store Mailing

City _____ State _____ Zip _____

Telephone: (_____)_____ Fax: (_____)_____

WIC Contact: _____ E-mail _____

Address _____ ☐ Same as Store Address ☐ Same as Store Mailing

City _____ State _____ Zip _____

Telephone: (_____)_____ Fax: (_____)_____

Bookkeeper: _____ E-mail _____

Address _____ ☐ Same as Store Address ☐ Same as Store Mailing

City _____ State _____ Zip _____

Telephone: (_____)_____ Fax: (_____)_____

13. HISTORY OF APPLICANT

A. Date store was purchased by present ownership? _____ (MM/DD/YYYY)

B. Have any of the current owners previously operated a retail grocery in Tennessee or other states? ☐ Yes ☐ No

IF YES, attach a list of stores, except for chain stores. Identify the store's full name and approximate date of application or last authorization, if known.

C. Has the store owner ever participated in the WIC Program? ☐ Yes ☐ No

D. Has any of the current owners or managers ever been associated with this or any other store which was suspended or disqualified in the WIC or Food Stamps Programs? ☐ Yes ☐ No

IF YES, attach an explanation identifying the person or corporation and the store name and location related to the violation(s) and the year of the violation(s), if known.

E. Has this store ever been denied or disqualified from SNAP? ☐ Yes ☐ No

IF YES, attach a written explanation, giving the date denied or disqualified and the reasons.

F. Has this store ever been placed on probation or received a Civil Money Penalty from SNAP? ☐ Yes ☐ No

IF YES, attach a written explanation including the probation period of amount of Civil Money Penalty.

G. Have any of the current owners, officers, or managers ever had a license denied, withdrawn or suspended, or fined for license violations (e.g., business or health licenses)? ☐ Yes ☐ No

IF YES, attach an explanation, listing the type of license, the reason for denial, fine or suspension, withdrawal or disqualification.

H. In the past 6 years have the current owners, officers, or mangers of this business been convicted of, or have had a civil judgement for: fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice? ☐ Yes ☐ No

IF YES, attach a written explanation specifying the name of the owner, officer, or manager, the activities involved, and date of judgment and court name.

PART III. STORE OPERATIONS AND SALES

14. INDICATE HOURS OF OPERATION FOR THIS STORE:

☐ Check here if store operates 24 hours, 7 days a week

OR

Monday	_____	Thursday	_____	Sunday	_____
Tuesday	_____	Friday	_____		
Wednesday	_____	Saturday	_____		

THIS APPLICATION MAY BE DENIED IF STORE IS NOT OPEN FOR BUSINESS AT LEAST SIX (6) DAYS PER WEEK

15. ARE THE STORE'S OPERATION HOURS CLEARLY POSTED? ☐ YES ☐ NO

16. SALES VOLUME FIGURES: PLEASE GIVE YEARLY (NOT MONTHLY) AMOUNT

A. Are figures below estimated or actual sales? ☐ Estimated or Projected ☐ Actual

Note: Only report estimated sales if you do not have actual sales figures for the most recent tax year. You may be required to provide updated information when actual sales figures are available.

B. For what tax year are the sales figures below provided? _____

C. Provide dollar amounts for all following sales volumes. **Bold items are required.**

Total WIC Sales	**$** _____	(If new applicant, provide best guess of WIC sales)
Total Food Sales	**$** _____	
Total Non Food Sales	$ _____	
Total Food Stamp Sales	$ _____	
Total Gross Sales	**$** _____	

17. DO YOU EXPECT THAT MORE THAN 50% OF THIS STORE'S ANNUAL REVENUE FROM THE SALE OF FOOD ITEMS WILL COME FROM WIC FOOD ALONE? ☐ YES (Skip to # 19) ☐ NO (Answer #18)

18. INDICATE THE FOLLOWING FORMS OF PAYMENT FOR TOTAL FOOD SALES (Check all that apply.)

☐ Cash / Personal Checks ☐ SNAP ☐ WIC ☐ Debit / Credit Cards

NOTE: YOU MAY BE ASKED TO SUBMIT RECORDS REGARDING SALES, INVOICES, AND/OR INVENTORY. THESE RECORDS SHALL BE ORIGINAL, ON COMMERCIALLY PRINTED INVOICE AND/OR RECEIPT PAPER READABLE AND PRESNTED IN A LOGICAL WAY. ALSO, YOU MAY BE ASKED FOR COPIES OF INCOME AND SALES TAX RELATED FORMS. *FAILURE TO MEET THESE REQUESTS SHALL RESULT IN DENIAL OF YOUR APPLICATION.*

Due to the federally issued Vendor Cost Containment Final Rule, the Tennessee WIC Program has chosen to prohibit authorization of new vendors expected to have more than fifty (50) percent of its annual food sales purchased with WIC. Also, the Tennessee WIC Program requires authorized grocers to carry a full market basket of foods to provide opportunity for price comparison shopping and nutrition information comparison. However, the Tennessee WIC Program has the sole responsibility to determine if approval of this application is necessary to assure participant access to WIC Program benefits.

19. INDICATE MAJOR WHOLESALER(S), DISTRIBUTOR(S), RETAILER(S), OR MANUFACTURER(S) FROM WHOM WIC FOODS ARE PURCHASED

Name ____

Address ____

City ______________________________________ State ______________ Zip ____________

Telephone: (_____)______________________ Fax: (_____)_________________________

Wholesaler Type (Check all that apply): ☐ Food Wholesaler ☐ Infant Formula Supplier

Name ____

Address ____

City ______________________________________ State ______________ Zip ____________

Telephone: (_____)______________________ Fax: (_____)_________________________

Wholesaler Type (Check all that apply): ☐ Food Wholesaler ☐ Infant Formula Supplier

Name ____

Address ____

City ______________________________________ State ______________ Zip ____________

Telephone: (_____)______________________ Fax: (_____)_________________________

Wholesaler Type (Check all that apply): ☐ Food Wholesaler ☐ Infant Formula Supplier

Name ____

Address ____

City ______________________________________ State ______________ Zip ____________

Telephone: (_____)______________________ Fax: (_____)_________________________

Wholesaler Type (Check all that apply): ☐ Food Wholesaler ☐ Infant Formula Supplier

IF WIC FOODS ARE PURCHASED FROM ADDITIONAL SOURCES, PLEASE ATTACH THEIR INFORMATION

PART IV. STATEMENTS AND CERTIFICATION

PRIVACY ACT STATEMENT - The collection of this information is authorized by Part 246.12 of Federal Regulations 7CFR, Ch.11 which governs the Special Supplemental Nutrition Program for Women, Infants, and Children. It 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 requested information, including the Tennessee Sales Tax and Business License Numbers is voluntary. However, failure to provide information may result in the denial or withdrawal of authorization to participate in the WIC Program. The purpose of collection of this information is for audit and enforcement of WIC Program regulations.

WARNING STATEMENT - Information in this application may be verified with other agencies. WIC Program participation shall be denied or withdrawn if any application information is false; in addition, you may be fined up to $25,000 or imprisoned for up to five years or both for concealing any material fact, making false statements or representation, or using any false writing or documentation in connection with the application. Authorization may be denied or terminated if the firm violates any laws or regulations issued by Federal, State, or local programs including SNAP for violating SNAP regulations.

CERTIFICATION AND SIGNATURE OF OWNER (or person who has the ability to apply on behalf of the store.)

1. **I apply for authorization for this store to take part in the WIC Program, and I have authority to enter into a WIC Vendor Agreement between this firm and the Tennessee Department of Health. I understand that I may be asked to provide proof of identification before the application can be accepted.**
2. **I understand that prices for WIC approved foods shall be competitive with and not exceed the average shelf price of other vendors in the same peer group and area by more than the stated percentage at the time of authorization as a WIC Vendor and throughout the period for which the WIC Vendor Agreement shall be in effect. (N.A. FOR PHARMACIES)**
3. **I understand that my stock of WIC approved foods shall meet the WIC Program requirements for minimum variety and quantity at the time of authorization as a WIC Vendor and throughout the period for which the WIC Vendor Agreement shall be in effect. (N.A. FOR PHARMACIES)**
4. **I understand that my authorization as a WIC vendor is subject to the WIC Program's verification of a positive compliance history with sanitation authorities. (N.A. FOR PHARMACIES)**
5. **I did read and do understand the penalties in the warning statement above. I understand that false or incomplete information provided to the WIC Program or violation of the terms of the WIC Vendor Agreement shall result in the termination of that agreement.**
6. **I understand that the ownership and management of this store will be responsible for understanding the requirements, policies, and procedures appearing in the WIC Vendor Handbook which is considered part of the WIC Vendor Agreement. This information shall be presented during both initial and follow-up training for this store's authorization as a WIC vendor. I further understand that I or another representative of the store will have an opportunity to ask questions during the training sessions.**

SIGNATURE _____ **DATE** _____

PRINT FULL NAME _____ **TITLE** _____

DAYTIME PHONE NUMBER _____

PLEASE RETURN THIS APPLICATION TO THE WIC REGIONAL OFFICE ADDRESS STATED IN THE ENCLOSED COVER LETTER. THE ADDRESS IN THE FOLLOWING STATEMENT FROM USDA IS ONLY FOR FILING COMPLAINTS AGAINST THE WIC PROGRAM.

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. E-mail: program.intake@usda.gov.

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