MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREVENTION AND HEALTH PROMOTION ADMINISTRATION
MARYLAND WIC PROGRAM

DATE RECEIVED BY STATE WIC OFFICE

APPLICATION FOR VENDOR AUTHORIZATION

INSTRUCTIONS: An owner, officer, manager, or other individual authorized to act on behalf of the applicant must complete the following information in its entirety and sign in appropriate areas to authenticate this document. *Failure to provide information as requested will be grounds for refusal to accept and process the application for authorization.*

Current Vendor Stamp (if applicable)

PURPOSE OF THE APPLICATION

Check A or B (Required):

_____ (A) For the first-authorization (new store) _____ (B) For re-authorization (current WIC vendor)

If A, have you applied for WIC within the last 2 years for the store named in the application?_____ Yes _____ No

If YES, when (the most recent)? (Month / Year) _____

BUSINESS TYPE

Check the appropriate type from the list below:

Sole Proprietorship

Privately Held Corporation

Partnership

Publicly Traded Corporation

Maryland Based? _____Yes _____ No

If Not Maryland Based List State _____

OWNERSHIP/CORPORATION IDENTIFICATION

OWNERSHIP/CORPORATION NAME		FEDERAL TAX I D NUMBER
OWNERSHIP/CORPORATION MAILING ADDRESS		P. O. BOX NUMBER
CITY	STATE	ZIP CODE
TELEPHONE NUMBER	ALTERNATE PHONE NUMBER	OWNERSHIP/CORPORATION E-MAIL ADDRESS (REQUIRED)

OWNERSHIP–LIST ALL CURRENT OWNERS. IF CORPORATION, LIST ALL OFFICERS (USE ADDITIONAL SHEET IF NECESSARY)

Please Print. NAME (LAST, FIRST, MIDDLE)	FULL ADDRESS	PHONE NUMBER

CONFLICT OF INTEREST

Are there any members of the ownership, management, or corporate officers who serve as board members or directors of an agency contracted with the Maryland Department of Health and Mental Hygiene (DHMH)? Yes No

Are there any members of the ownership, management, or corporate officers who serve as board member appointees or are elected officials with oversight of a public or private health agency? Yes No

Are there any members of the immediate family of the ownership, management, or corporate officers who serve as board members or directors of an agency contracted with DHMH? Yes No

If yes to any of these three questions, please specifiy relationship and circumstance in detail. Attach additional sheets if needed.

Revised 01/14

STORE DETAILS

OWNER/CORPORATION NAME (OR Current Contract)			CURRENT WIC VENDOR NUMBER
STORE NAME			
STORE STREET ADDRESS			P. O. BOX NUMBER
CITY	COUNTY	STATE	ZIP CODE
STORE TELEPHONE	STORE E-MAIL ADDRESS	STORE FAX NUMBER	
STORE CONTACT PERSON FOR WIC PROGRAM	CONTACT PERSON'S TITLE		
STATE SALES TAX ID	FOOD STAMP AUTHORIZATION # **(required)**	FOOD STAMP AUTHORIZATION DATE	

How long has this location been open under the current ownership? Years ☐ Months ☐

FACILITY AND OPERATION

Is the facility ADA (Americans with Disabilities Act) Compliant ? YES ☐ NO ☐

Date of last Health Department Inspection: ☐ Passed ☐ Failed

Store Type: ☐ Food Store ☐ Food Store/Pharmacy ☐ Pharmacy Only ☐ Commissary

Store size : square feet Allotted storage size: square feet

Do you expect your WIC sales to exceed 50% of your total food sales?
YES ☐ NO ☐

Hours of Operation
If open 24 hours, 7 days check here: ☐
If not, complete the schedule at right.
Do not include holiday shortened or extended times.

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Infant Formula Supplier (*Required*):

Company Name :

Address : Phone Number :

Total Annual Gross sales, all products: $	Monthly Food Stamp sales: $
Total Annual Food sales: $	Is alcohol or tobacco sold? ☐ YES ☐ NO
Number of registers or scanners:	If store has scanners, do they differentiate WIC items? ☐ YES ☐ NO

BANKING INFORMATION (If possible, please attach a VOIDED check)

BANK NAME:	EFFECTIVE DATE OF ACCOUNT:
BANK ADDRESS:	
BANK ACCOUNT NUMBER:	
BANK ROUTING (ABA) NUMBER: *(9 DIGIT NUMBER AT BOTTOM LEFT ON DEPOSIT SLIP)*	

Revised 01/14

HISTORY

1. List all stores owned by any of the owners or managers that are currently WIC vendors in Maryland. (Use additional pages if needed.) Please Print

OWNER NAME	STORE NAME AND ADDRESS

2. If any store has been acquired within the last three years, what is the relationship, if any, of the current owner(s) to the previous owner(s)? **Please Print**

STORE NAME AND LOCATION	DATE ACQUIRED	CURRENT OWNER NAME	PREVIOUS OWNER NAME	RELATIONSHIP

The Maryland WIC Program shall review the accuracy of all applicant qualifications and shall make appropriate authorizations based upon the results of such review.

CERTIFICATION AND SIGNATURE OF OWNER, OFFICER OR MANAGER (Person who has the authority to apply on behalf of the business):

1. I am applying for authorization as a vendor for the Maryland WIC Program and I have authority to contract for the business.
2. I certify that during the last six (6) years that the vendor applicant or any of the vendor applicant's current owners, officers, or managers have not been indicted for, convicted of, or had a civil judgement entered against them for any activity indicating a lack of business integrity. Activities indicating a lack of business integrity include fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, and obstruction of justice.
3. I consent to the release of necessary and required information on myself and/or this company/business to the United States Department of Agriculture, Food Nutrition Service; the Maryland Department of Health and Mental Hygiene and its contractor's agents; and the Food Stamp Program, for the purpose of determining eligibility, program coordination, and conducting authorization and compliance activities.
4. I certify that neither the vendor applicant nor any of the vendor applicant's current owners, officers, or managers have been disqualified, suspended, or have been assessed a civil money penalty from any USDA/FNS Program.
5. I hereby certify that the information presented in this application is true and factual to the best of my knowledge, information, and belief. I understand that misrepresentation of the information contained herein will nullify this application or will lead to contract termination if discovered at a later date.

OWNER/REPRESENTATIVE SIGNATURE	DATE
OWNER/REPRESENTATIVE PRINTED NAME	TITLE

The Maryland WIC Program is not obligated to contract with any retailer. Each applicant has the right to appeal the decision if the application is denied. Expiration of an Agreement is not subject to appeal.

The United States Department of Agriculture (USDA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint, write the Administrator, Food and Nutrition Service, USDA, 301 Park Center Drive, Alexandria, VA 22302. USDA is an equal opportunity employer.

If the application preparer is different from the owner or corporate officers, please fill the preparer's information below.

NAME:_____ ADDRESS:_____

PHONE:_____ EMAIL:_____

RELATIONSHIP TO OWNER:_____

Revised 01/14