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

<table>
<tr>
<td rowspan="7">2019 - 2021 PHARMACY APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE TENNESSEE WIC PROGRAM</td>
<td>FOR WIC USE ONLY</td>
</tr>
<tr><td>REG _____ CO _______ VENDOR NO __________</td></tr>
<tr><td>Peer Group_________ Owner ID: Y N</td></tr>
<tr><td>Sanitation Score____________ Date____________</td></tr>
<tr><td>Vendor Rep __________________________________</td></tr>
<tr><td>Date Received _________________ (MM/DD/YYYY)</td></tr>
<tr><td>Date Approved _________________ (MM/DD/YYYY)</td></tr>
</table>

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), FRONT END, AND CERTIFICATION LEVEL (IF APPLICABLE)**

   VAR ____________________ FRONT END _______________ CERTIFICATION LEVEL ☐ 1 ☐ 2 ☐ 3

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 ___________

County __________________________ 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:

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 is 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 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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