



RETAILER AUTHORIZATION APPLICATION

OWNER/CORPORATION NAME		CORPORATE PHYSICAL STREET ADDRESS	
CORPORATE P.O. BOX	CITY	STATE	ZIP CODE
CORP. TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS	
CORP. CONTACT PERSON FOR WIC	CONTACT PERSON'S TELEPHONE NUMBER	CONTACT PERSON'S E-MAIL ADDRESS	
STORE NAME		STORE E-MAIL ADDRESS	
STORE PHYSICAL STREET ADDRESS		P. O. BOX NUMBER	
CITY	COUNTY	STATE	ZIP CODE
STORE TELEPHONE NUMBER	STORE FAX NUMBER	PHARMACY TELEPHONE NUMBER	
STORE MANAGER'S NAME		STORE CONTACT PERSON FOR WIC PROGRAM	
FEDERAL TAX ID NUMBER		FOOD STAMP AUTHORIZATION NUMBER & EFFECTIVE DATE	
MISSOURI SEC. OF STATE CHARTER NUMBER	How long has this location been open under the current ownership? _____ Years _____ Months		

FACILITY AND OPERATION

Store type: Grocery Store _____ Grocery Store with Pharmacy _____ Pharmacy Only _____

Square footage of the store: _____ Square footage allotted for food sales: _____

<p>Hours of Operation:</p> <p>If open 24 hours, 7 days check here _____</p> <p>If not, complete the schedule at right.</p> <p>Do not include holiday shortened or extended times.</p>	Sunday	
	Monday	
	Tuesday	
	Wednesday	
	Thursday	
	Friday	
	Saturday	

Will more than 50% of the store's food sales be from the redemption of WIC checks? YES NO

Number of registers or scanners: _____ If scanners, do they differentiate WIC items? YES NO

SANITATION: A copy of the most recent sanitation report must be included with this application.

Are there unmet work orders or corrective action plans for sanitation violations? YES NO

For questions below provide the name of company, contact person, address and telephone

Distributor store uses to order grocery items:	Distributor store uses to order milk items:

Distributor store uses to order Contract Infant Formula:	Distributor store uses for Special Infant Formula/Pharmacy:

SIGNATURE	TITLE	DATE



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The Missouri 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.

This program is operated in accordance with the U.S. Department of Agriculture and the Missouri Department of Health and Senior Services policies, which prohibit discrimination because of race, color, national origin, disability, gender, age, religion or political affiliation.

INSTRUCTIONS: An owner, officer, or manager must complete the following information in 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.

OWNERSHIP/CORPORATION TYPE

Check the appropriate type from the list below:

<input type="checkbox"/> Sole Proprietorship	Privately Held Corporation <input type="checkbox"/> Yes <input type="checkbox"/> No	Missouri Based? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Partnership	Publicly Traded Corporation <input type="checkbox"/> Yes <input type="checkbox"/> No	Missouri Based? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> LLC	If Not Missouri Based List State:	

OWNERSHIP – List all current owners. If Corporation, list all officers and titles (Use additional sheet if necessary)

INDICATE PRINCIPLE OWNER OR CONTACT NAME HERE:

PRINT - NAME (LAST, FIRST, MIDDLE)	FULL ADDRESS	SOCIAL SECURITY NUMBER	DATE OF BIRTH

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 Missouri Department of Health and Senior Services (DHSS)? **YES** **NO**

Are there any members of the ownership, management, or corporate officers who serve as board members, 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 the DHSS? **YES** **NO**

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



CURRENT VENDOR NUMBER
(if applicable)

WIC RETAILER SALES INFORMATION – Must be within the past fiscal year

1. Indicate time period for supplied information: _____ to _____ (month - year) (month - year)	
2. Other (Taxable) Food Sales for the past fiscal year:	\$
3. WIC Food Sales for the past fiscal year:	\$
4. Food Stamps (SNAP) Sales for the past fiscal year:	\$
5. Alcohol Sales for the past fiscal year:	\$
6. Tobacco Sales for the past fiscal year:	\$
7. Other Non-Food Sales for the past fiscal year:	\$
8. Gross Sales for the past fiscal year:	\$

List the number of retail grocery stores owned by any of the owners and if they are currently a WIC authorized store location in Missouri. Provide a list of the store name, address, city and state on a separate sheet.

Total Number of Retail Grocery Stores: _____ **Number of WIC Authorized Stores:** _____

The Missouri 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 apply for authorization as a vendor for the WIC Program, and I have authority to sign for the business.
2. I certify that during the last six (6) years that the retailer applicant or any of the retailer applicant's current owners, officers, or managers have not been indicted for, convicted of or had a civil judgment 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, arson, conspiracy, removal from federal, state, or local programs and other evidence reflecting on business integrity and reputation of the applicant.
3. I consent to the release of necessary and required information on myself and/or this company/business to the Food and Nutrition Services (FNS) administered by the United States Department of Agriculture; the Missouri Department of Health and Senior Services and its contractor's agents; and the Supplemental Nutrition Assistance Program, for the purpose of determining eligibility, program coordination, and conducting authorizations and compliance activities.
4. I certify that neither the retailer applicant nor any of the retailer applicant's current owners, officers, or managers have been disqualified, suspended, or have been assessed a civil money penalty from any federal or USDA/FNS Program.
5. I certify that since this Agreement is federally funded I shall abide by the provisions of Appendix B 45 CFR Part 76, Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction which is incorporated herein as if fully set out.
6. 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 agreement termination if discovered later.

OWNER / REPRESENTATIVE SIGNATURE:	DATE:
PRINT OWNER / REPRESENTATIVE NAME:	TITLE: