Inter-Tribal Council of Nevada WIC Program

Vendor Application

680 Greenbrae Dr. Suite 222
Sparks, Nevada 89431
Phone: (775) 355-0600 Fax: (775) 355-5217

Submission of this application **does not** constitute authorization to participate in the ITCN WIC Program. This application is **NOT** a Contract. Participation in the ITCN WIC Program will not be authorized until all completed application materials have been received, evaluated and **approved**.

PLEASE ANSWER ALL QUESTIONS AND SIGN. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

The WIC Program is an equal opportunity program and may not discriminate on the basis of race, color, disability, age, national origin, or gender.

Store Name: _____

Doing Business As (dba):_____

Business Location: _____

City: _____County:_____State: _____Zip Code: _____

Telephone: (___)_____ FAX :(___)_____Other: (___)_____

Mailing Address: _____

City: _____County:_____State: _____Zip Code: _____

The legal structure of this business is:

☐ Corporation ☐ Co-operative
☐ Limited Liability ☐ Partnership
☐ Sole Proprietorship ☐ Other

If applicable, Name of partner (s): _____

If applicable, Date and Place of Incorporation, Organization: _____

Name of owner(s), partners, members, or corporate officer(s) responsible for the operation of each applicant store(s). If a Partnership, Limited Liability Company, or Corporation, percent of ownership.

Name: _____% ownership_____

Address: _____

City: _____State: _____Zip Code: _____

Phone: (_____)_____Fax: (_____)_____

Other : (____)_____ □ Cell □ Pager

Other Contacts: _____

Mailing address if different: _____

City: _____State: _____Zip Code: _____

BANK INFORMATION

Name of the store or outlet's bank: _____

Branch: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone: (_____)_____Fax: (_____)_____

Account Number: _____ ABA Routing #: _____

Federal ID #: _____ Effective Date: _____

INSURANCE INFORMATION

Name of Liability Insurance Company:_____

Liability Insurance Effective Date: _____

Liability Insurance Expiration Date: _____

Liability Insurance Coverage: _____

TRAINING INFORMATION

Specify the name of the individual(s) who will be responsible for WIC oversight and training of store personnel on WIC procedures and communicating WIC program changes to the cashiers, bookkeepers and other interested parties.
General Training Representative(s)

Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone: (_____) _____Fax: (_____) _____

Other: (____) _____ □ Cell □ Pager

OTHER PERSONNEL

Please list the name, phone number, and email address of the individual to contact regarding the following:

Cashier Training:

Name	Phone #	Email

Operations:

Name	Phone #	Email

Newsletter Distribution:

Name	Phone #	Email

Store Openings and Closings:

Name	Phone #	Email

Vendor Contract:

Name	Phone #	Email

Regional/District Manager:

Name	Phone #	Email

Management WIC Contact Information:

Name	Phone #	Email

Corporate Contact:

Name	Phone #	Email

WIC Corporate Accounting Contact:

Name	Phone #	Email

Regional/District Manager:

Name	Phone #	Email

Store's Primary Bookkeeper:

Name	Phone #	Email

Hours to contact bookkeeper _____A.M. to _____P.M.

(Include additional sheets if necessary)

<u>Store Information</u>

To be classified as a chain store, the "chain" must have 6 or more store locations.

□ **Yes** □ **No** Is this store a national chain store? (Generally multi-state operations)

□ **Yes** □ **No** Is this store a regional chain store? (Confined within the state of Nevada)

□ **Yes** □ **No** Is this store a local chain store? (Usually within the same geographic location, but not statewide)

□ **Yes** □ **No** Is this store an independent store? (Under the same owner/operator)

□ **Yes** □ **No** Does this store feature a full, well-stocked line of grocery items with 3 or more brands to choose among most food lines?

□ **Yes** □ **No** Under the ITCN WIC contract you will be required to stock two fresh fruits and two fresh vegetables for participants. Does this location have the space and/or ability to comply?

□ **Yes** □ **No** Does this store feature non-grocery items as its major retail products?

□ **Yes** □ **No** Do you expect that more than 50 percent of your annual revenue from the sale of food items will be derived from WIC Food Instruments?

☐ **Yes** ☐ **No** During the last 6 years, have you or any current owner, officer or manager been convicted of or received a civil judgment 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** Is there a current disqualification (or civil monetary penalty assessed in lieu of disqualification for hardship and for which the disqualification period would otherwise have been imposed has not expired) from the Food Stamp Program against the applicant?

☐ **Yes** ☐ **No** Does the store participate in the State of Nevada WIC Program?

☐ **Yes** ☐ **No** Has the store or its owner(s), officer(s), or manager(s) ever been suspended or disqualified from WIC in Nevada or any other state?

If yes, give the name of the owner(s), officer(s), manager(s), and store(s) location, and the reason(s) and date(s) of suspensions or disqualifications.

_____
_____
_____.

☐ **Yes** ☐ **No** Is this store currently authorized to accept Food Stamps in Nevada or any other state?

If yes, list the Food Stamp Authorization Number: _____

☐ **Yes** ☐ **No** Has the store, its owners, officers or managers ever been suspended or disqualified from the Food Stamp Program in Nevada or any other state?

If yes, give the name of the owners, managers, any officers, store(s), location(s), the reason(s) and date of suspension or disqualification:

_____
_____

☐ **Yes** ☐ **No** Has the store ever been cited by the State or County health inspector for a violation?

If yes was your license/permit revoked?_____

If yes when: From: _____to_____

If yes, describe the violation(s). (Provide details)

_____
_____
_____

Attach a copy of the stores current health certificate (operating permit).

☐ **Yes** ☐ **No** Does the store comply with the applicable provision of the **Americans with Disabilities Act of 1990**?

☐ **Yes** ☐ **No** Does this store support a Store/Loyalty Shopping card?

☐ **Yes** ☐ **No** Does this store location have internet access through DSL or Broadband?
If yes, who is your service provider?_____

☐ **Yes** ☐ **No** ITCN WIC uses Electronic Benefits Transfer (EBT) internet access and a 3 pronged electrical outlet is required at the locations you plan to place the WIC EBT POS equipment. Will this be available?

Provide the following information for the store:

Number of store locations locally: _____

Number of store locations statewide: _____

Number of store locations nationally: _____

Number of full-time cashiers: _____

Number of part-time cashiers: _____

Number of checkout lanes: _____

Are your cash registers currently programmed to detect WIC Authorized vs. Non-Authorized products (independent of any State of Nevada provided equipment)?

Days and hours of store operation:

☐ This location is open 24 hours a day 7 days a week.

OR

Sunday	From	To
Monday	From	To
Tuesday	From	To
Wednesday	From	To
Thursday	From	To
Friday	From	To
Saturday	From	To

Name and address of infant formula wholesaler or supplier:

Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Phone: (_____)_____Fax: (_____)_____

NOTE: INFANT FORMULA MUST BE PURCHASED FROM A SUPPLIER ON THE ATTACHED LIST
Please attach the most recent infant formula invoice for Similac Advance Powder and Gerber Good Start Soy.

General Information

PLEASE READ CAREFULLY AND SIGN BELOW

The undersigned is authorized to act on behalf of the applicant indentified on Page 1, who is applying for authorization to participate in the ITCN WIC Program. By submitting this application, **the undersigned has declared that the business is open, fully operational and authorized to accept Food Stamps.** The undersigned has reviewed, verified and understands the information contained, requested and attached to this Vendor enrollment packet.

This application is **only a request** for a WIC Vendor Contract and **does not** constitute a Contract nor does it guarantee authorization to participate in the ITCN WIC Program. The ITCN WIC Program or its designee may verify the information contained in this application during an on-site visit.

1. I certify that the enclosed Price Monitoring Survey form reflects the actual highest shelf price.
2. I certify that all information submitted on this application is accurate and complete.
3. I understand that if the application is approved and a Contract is executed, I will be bound by all rules, and requirements of the ITCN WIC Program, in addition to the terms and conditions of the WIC Vendor Contract.
4. I understand that if any information contained in this application is found to be false, the application will be denied; or if authorized can result in being suspended or disqualified from participating in the ITCN WIC Program.
5. The undersigned declares that he/she is the store's sole owner or has the delegated legal authority to sign this application on behalf of the owner.

Signature: _____ Date: _____

Name (Print): _____

Title (Print): _____