

**New Jersey Department of Health  
WIC Services  
PO Box 364  
Trenton, NJ 08625-0364**

**APPLICATION FOR WIC VENDOR AUTHORIZATION**

**Important: This application must be completed in its entirety and all required documents must be attached. An incomplete submission may result in the delay or denial of your application.**

**Submit Original to State WIC Services; retain a copy for your records.**

FOR STATE USE ONLY	
Date _____	
Type of Application:	
<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal
<input type="checkbox"/> Change of Ownership	<input type="checkbox"/> Update
Vendor # _____	
FY _____	
STARS Review <input type="checkbox"/> Yes	

**BUSINESS TYPE**

Business Type (Check only one box)

Sole Proprietorship     Partnership     Corporation     Commissary     Pharmacy

**OWNERSHIP / CORPORATE IDENTIFICATION**

Trade Name of Business		Name of Owner or Corporation	
Street Address of Business		Owner or Corporation Mailing Address	
Mailing Address for Store (if different)		City, State, Zip Code	
City, State, Zip Code		Social Security No	Federal ID Number
County	Telephone Number	Telephone Number	Fax Number
Name of Person Responsible for WIC Matters		E-Mail Address	
State Sales Tax ID No.	Sanitary Code Inspection <i>(Required-attach a copy of permit)</i>	SNAP Authorization Number <i>(Required-attach a copy of permit)</i>	SNAP Authorization Date

How long has this location been under the current ownership?    \_\_\_\_\_ Years    \_\_\_\_\_ Months

**OWNERSHIP – LIST ALL CURRENT OWNERS. IF CORPORATION, LIST ALL OFFICERS AND TITLES.  
(Attach additional sheet if necessary.)**

(1) Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_    Telephone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

(2) Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_    Telephone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

(3) Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_    Telephone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**APPLICATION FOR WIC VENDOR AUTHORIZATION  
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**CONFLICT OF INTEREST**

1. During the last six (6) years, have you or any members of the immediate family of any owners, managers, or corporate officers served as board members or directors of an agency contracted with the New Jersey Department of Health?  Yes  No
2. During the last six (6) years, have you or any members of the immediate family of any owners, managers, or corporate officers served as board member appointees, or as elected officials with oversight of a public or private health agency?  Yes  No
3. During the last six (6) years, have you or any members of the immediate family of the owners, managers, corporate officers, or employees been sanctioned by other government entities (i.e., WIC, SNAP, NJ Division of Taxation, etc.)?  Yes  No
4. If Yes to any of the above questions, please specify relationship and circumstances in detail. *Attach additional sheets, if necessary.*

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**STORE OPERATIONS**

- Is the facility ADA (Americans with Disabilities Act) compliant?  Yes  No  
*Submit a hard copy of latest health inspection report.*
- Store Type:  Food Store  Food Store/Pharmacy  Pharmacy Only  Commissary  Super Store
- Is store a permanent fixed location?  Yes  No
- Do you expect to derive more than 50% of the store's annual food sales revenue from WIC food instruments?  Yes  No
- Do you sell kosher foods?  Yes  No

Hours of Operation:

- a. Is store open 24 hours per day, 7 days a week?  Yes  No

(1) List store hours (do not include holiday shortened or extended hours):

	SUN	MON	TUES	WED	THUR	FRI	SAT
Opens:	_____	_____	_____	_____	_____	_____	_____
Closes:	_____	_____	_____	_____	_____	_____	_____

- (2) Does this store location close for any period of time throughout the hours of operation?  Yes  No

If Yes, please specify hours and reason:

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Total Annual Gross Sales, All Products     **\$** \_\_\_\_\_  
 Total Annual Food Sales                         **\$** \_\_\_\_\_  
 Monthly SNAP Sales                               **\$** \_\_\_\_\_

Square footage of retail space (include square footage allocated solely for food products, both WIC and Non-WIC foods): \_\_\_\_\_

Number of Registers or Scanners: \_\_\_\_\_

- If store has scanners, do they differentiate WIC items?  Yes  No

- Are you interested in receiving information on the Food Trust(s) Healthy Corner Store Initiative?  Yes  No

**APPLICATION FOR WIC VENDOR AUTHORIZATION  
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**STORE OPERATIONS, CONTINUED**

Name of Primary Grocery Wholesaler: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Name of Infant Formula Supplier: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**BANK INFORMATION**

Name of Bank: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_  
Bank Telephone Number: \_\_\_\_\_  
Checking Bank Account Number: \_\_\_\_\_  
Checking Bank Routing (ABA) Number: \_\_\_\_\_  
Effective Date of Account: \_\_\_\_\_ **Attach a copy of a voided check.**

**HISTORY**

List all stores owned by any of the owners or managers that are currently WIC vendors in New Jersey. (Use additional pages, if necessary.)

(1) Name of Owner: \_\_\_\_\_  
Store Name: \_\_\_\_\_  
Store Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

(2) Name of Owner: \_\_\_\_\_  
Store Name: \_\_\_\_\_  
Store Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

If any store has been acquired within the last year, what is the relationship, if any, of the current owner(s) to the previous owner(s)?

(1) Store Name: \_\_\_\_\_  
Store Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Date Acquired:: \_\_\_\_\_  
Current Owner Name: \_\_\_\_\_  
Previous Owner Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

(2) Store Name: \_\_\_\_\_  
Store Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Date Acquired:: \_\_\_\_\_  
Current Owner Name: \_\_\_\_\_  
Previous Owner Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

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**CERTIFICATION**

**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 contract for the business.
2. I certify that during the last six (6) years 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 for myself and/or this company/business to the United States Department of Agriculture, Food Nutrition Services; the New Jersey Department of Health and it's contractor's agents; and the Supplemental Nutrition Assistance Program (SNAP), for the purpose of determining eligibility, program coordination, and conducting authorizations 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 understand that this is only a request for a WIC vendor contract and does not constitute a contract. I understand that the WIC Program will consider the enclosed Selection Criteria when evaluating my application. I understand that if I am selected for Program participation, the New Jersey WIC Program does not guarantee a specific amount of WIC business.
6. I understand that the WIC Program provides only specific authorized food items for the purpose of improving nutritional status and health of WIC participants. I further understand the following:
  - a. My application to WIC must document that as a normal business activity my store stocks and shelves on a normal daily basis the minimum stock of WIC authorized food items. The minimum stock items are in my store at this time.
  - b. A state WIC representative will make an unannounced visit to my store during the application review period. The representative will verify that the minimum stock is available in the store.
  - c. A vendor is responsible to provide acceptable (signed affidavit) documentation of the vendor's total food sales revenue annually upon request.
7. Disqualification from the WIC Program may result in a disqualification from the Supplemental Nutrition Assistance Program (SNAP).
8. The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)  
  
 If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).  
  
 Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).  
  
 USDA is an equal opportunity provider and employer.
9. The New Jersey 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.
10. WIC Services authorization may not be transferred to new owners, partners, corporations, or locations. An unauthorized individual or firm accepting or redeeming WIC checks is subject to administrative sanctions.
11. 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.

Name of Owner or Authorized Agent (Print)	Title
Signature	Date