

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:

- ☐ Initial ☐ Renewal
☐ Change of Ownership
☐ Update

Vendor # _____

FY _____

STARS Review ☐ Yes

BUSINESS TYPE

Business Type (Check only one box)

- ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Commissary

OWNERSHIP / CORPORATE IDENTIFICATION

Trade Name of Business		Name of Owner or Corporation	
Street Address of Business		Owner or Corporation Mailing Address	
City, State, Zip Code		City, State, Zip Code	
County	Telephone Number	Federal Tax ID Number	
Mailing Address for Store (if different than street address)		Telephone Number	Fax Number
City, State, Zip Code		Store Contact E-Mail Address	
Name of Person Responsible for WIC Matters		SNAP Authorization Number (Required-Attach a copy)	Sanitary Inspection Report (Required-Attach a copy)

Provide purchase date: _____ (Required - Attach legal verification of store purchase/sales agreement)

**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: _____
Owner Email Address: _____ Percentage of Ownership: _____

(2) Name: _____
Street Address: _____
City, State, Zip: _____
Social Security Number: _____ Telephone Number: _____
Owner Email Address: _____ Percentage of Ownership: _____

(3) Name: _____
Street Address: _____
City, State, Zip: _____
Social Security Number: _____ Telephone Number: _____
Owner Email Address: _____ Percentage of Ownership: _____

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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

Store Type: ☐ Food Store ☐ Food Store/Pharmacy ☐ *Kosher ☐ Commissary ☐ Super Store

*If your Store Type is Kosher, please attached the most recent copy of your statement of Rabbinical Supervision issued by the New Jersey Office of Attorney General, Division of Consumer Affairs, Bureau of Kosher Enforcement

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

Do you sell Alcohol? ☐ Yes ☐ No

Do you sell Tobacco? ☐ 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:

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*): _____

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POINT OF SALE (POS) SYSTEM	
Number of Registers	Number of Current or Planned eWIC Enabled Registers
Current POS System	
<p align="center">NJ WIC requires authorized vendors to be equipped with an eWIC capable Integrated System</p> <p align="center">Refer to the POS Provider List for eWIC capable systems</p> <p>Integrated System refers to a store's point of sale (POS) equipment that is able to process eWIC and other transaction types (cash, debit, credit) without separating food items (also referred to as a Mixed Basket transaction). Integrated systems also generally have built in scanning capabilities, price lookup, and integration with store inventory management systems.</p>	
PARTICIPANT ACCESS/ACCOMMODATIONS	
<p>1. Are there geographic barriers or conditions, that would significantly restrict participants access to other retail stores resulting in a WIC participants inability to reach other NJ WIC Authorized stores in your area? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2. Does your store provide any of the following accommodations? (Select all accommodations that apply)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Access Ramp</div> <div style="width: 50%;"><input type="checkbox"/> Automatic Doors</div> <div style="width: 50%;"><input type="checkbox"/> Shopping Assistants</div> <div style="width: 50%;"><input type="checkbox"/> Electric Shopping Carts</div> <div style="width: 50%;"><input type="checkbox"/> Accessible Product Display/Shelf Heights</div> <div style="width: 50%;"><input type="checkbox"/> Accessible Produce Bag Heights</div> <div style="width: 100%;"><input type="checkbox"/> Designated Handicap Parking Spaces</div> <div style="width: 100%;"><input type="checkbox"/> A minimum of one checkout aisle with width and arrangement which are wheelchair friendly</div> <div style="width: 100%;"><input type="checkbox"/> Other:</div> </div> <p>If accommodations are not readily achievable at your store location, will store personnel assistance be provided? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>3a. What is the primary language spoken by store owner?</p>	
<p>3b. What other languages are spoken by store owner and personnel?</p>	
<p>4. Does your store provide accommodations for religious dietary needs or culturally specific food items?</p> <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 20px;"><input type="checkbox"/> Halal</div> <div style="margin-right: 20px;"><input type="checkbox"/> Kosher</div> <div><input type="checkbox"/> Other culturally specific food items. If so, identify: _____</div> </div>	

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DESIGNATION OF PRIMARY GROCERY AND INFANT FORMULA MANUFACTURER, RETAILER AND WHOLESALE DISTRIBUTOR

Authorized WIC Vendors must provide the name, address and telephone number of the Manufacturer, Retailer or Wholesale Distributor of the business establishment you purchase NJ WIC Approved Food Items and Contracted Infant Formula.

Designated Manufacturer, Retailer or Wholesale Distributors may be contacted by the SA to confirm pricing and purchases.

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 or a letter from your bank confirming the account information.

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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 understand that this is only a request for WIC vendor authorization and does not constitute a contract.
2. I apply for authorization as a vendor for the WIC Program, and I have authority to contract for the business.
3. 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 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.
4. 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 its contractor's agents; and the Supplemental Nutrition Assistance Program (SNAP), for the purpose of determining eligibility, program coordination, and conducting authorizations and compliance activities.
5. 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.
6. 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.
7. 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.
 - d. I shall facilitate the ability of the WIC Program to directly contact my vendors and wholesalers to verify product purchases and inventory.
8. Any retailer in the process of applying to become a NJ WIC authorized retailer must have a Point of Sale (POS) system that is eWIC ready and equipped to accept NJ eWIC cards. All certified POS systems that meet this NJ eWIC readiness criteria can be found here: [POS provider list.pdf](#)
 - a. The State Agency shall deny the authorization of a Vendor that is unable to transact eWIC purchases no later than 60 days from the date when the interested retailer receives their assigned NJ WIC Vendor Identification (ID) Number.
9. Disqualification from the WIC Program may result in a disqualification from the Supplemental Nutrition Assistance Program (SNAP).
10. 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 complaint of discrimination, completed the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and 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: mail: U.S. Department of Agriculture, Office of Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
11. 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.
12. 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.
13. I certify under penalties of law that the information and the statements made in this application is complete, true, and accurate to the best of my understanding, and that any intentional, false, or misrepresentation of material fact shall nullify this application, or lead to contract termination, in addition to prosecution, civil and criminal penalties under applicable Federal and/or State laws.

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