



Nevada WIC Vendor Application

ENROLLMENT PERIOD: October 1, 2021 - September 30, 2024

Submission of this application **does not** constitute authorization to participate in the Nevada WIC Program. This application is **NOT** an Agreement. Participation in the Nevada 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

This institution is an equal opportunity provider. Esta institución es un proveedor que ofrece igualdad de oportunidades.

<https://www.fns.usda.gov/cr/fns-nondiscrimination-statement>

Store Name: _____

Doing Business As (dba): _____

Business Location: _____

City: _____ County: _____ State: _____ Zip Code: _____

Telephone: (____) _____ FAX:(____) _____ Email: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

The legal structure of this business is:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Co-operative |
| <input type="checkbox"/> Limited Liability | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> 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: () _____

Email : _____

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 (please attach copy of current liability document)

Name of Liability Insurance Company: _____

Liability Insurance Effective Date: _____

Liability Insurance Expiration Date: _____

Liability Insurance Coverage: _____

CONTACT 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 Manager

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

OTHER PERSONNEL

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

Store Manager:

Name	Phone #	Email
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Operations:

Name	Phone #	Email
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Newsletter Distribution:

Name	Phone #	Email
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Store Openings and Closings:

Name	Phone #	Email
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Vendor Agreements:

Name	Phone #	Email
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Corporate Contact:

Name	Phone #	Email
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Regional/District Manager:

Name	Phone #	Email
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Store's Primary Bookkeeper:

Name	Phone #	Email
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INFANT FORMULA SUPPLIER

NOTE: INFANT FORMULA MUST BE PURCHASED FROM A SUPPLIER ON THE ATTACHED LIST

Name and address of infant formula wholesaler or supplier:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

You must provide a copy of your latest infant formula invoice

STORE INFORMATION

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 meet the definition of a Full Line Grocery Store as defined in the attachment for Vendor Selection and Limiting Criteria?

Yes **No** Nevada WIC Authorized Vendors will be required to stock seven varieties of fresh fruits and seven varieties of fresh vegetables for participants. Does this location have the space and/or ability to comply?

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

Yes **No** Does this store have a Store Loyalty card? If yes, name: _____

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/Supplemental Nutrition Assistance Program (SNAP) against the applicant?

Yes **No** Does the store participate in the Inter-Tribal Council of Nevada, WIC?

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/SNAP in Nevada or any other state?

If yes, list the Food Stamp/SNAP Authorization Number: _____

Yes **No** Has the store, its owners, officers or managers ever been suspended or disqualified from the Food Stamp Program/SNAP 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 location have internet access through DSL or Broadband?
If yes, who is your service provider? _____

Yes **No** The state of Nevada 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 statewide: _____

Number of store locations nationally: _____

Number of Point of Sale Terminals: _____

Number of Self-Check out terminals: _____ Does Self-Check out accept eWIC? _____

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

Please complete the attached Electronic Cash Register (ECR) Form

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

GENERAL INFORMATION

PLEASE READ CAREFULLY AND SIGN BELOW

The undersigned is authorized to act on behalf of the applicant identified on Page 1, who is applying for authorization to participate in the Nevada WIC Program. By submitting this application, **the undersigned has declared that the business is open, fully operational and authorized to accept Food Stamps/SNAP.** 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 Agreement and **does not** constitute an Agreement nor does it guarantee authorization to participate in the Nevada WIC Program. The Nevada State WIC Program or its designee may verify the information contained in this application during an on-site visit.

1. I certify the enclosed Price Monitoring Survey reflects 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 an Agreement is executed, I will be bound by all rules, and requirements of the Nevada WIC Program, in addition to the terms and conditions of the WIC Vendor Agreement.
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 Nevada 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): _____

Please return your completed application to the Vendor Coordinator via email at **DPBHWICVendor@health.nv.gov** or fax to **775-684-4246.**

Applications may also be mailed to:

**State of Nevada WIC
Attn: Vendor Coordinator
400 West King St, Ste 300
Carson City, NV 89703**