GEORGIA WIC PROGRAM
APPLICATION FOR VENDOR AUTHORIZATION AND INSTRUCTIONS
PHARMACY APPLICANTS ONLY

Complete this application in its entirety. Incomplete applications will not be processed. Any misrepresentations and/or omissions made with respect to the information requested in this application may result in denial of the application or termination of the vendor agreement.

Check (√) one

A.	☐	**New Application**	☐	**Re-Authorization** ***(Enter current vendor number)***	**VENDOR NUMBER (VN#)**
	☐	**Change of Ownership**	☐	**Change of Pharmacy or Corporate Name/ Address**	
	☐	**Addition of New Pharmacy Locations** ***(Attach list of existing WIC authorized pharmacies owned by the corporate vendor.)***			

B.	1. Is this pharmacy owned by a corporate entity?	☐	Yes	☐	No
	2. Enter the total number of pharmacies for which the applicant is seeking authorization. ***(If seeking authorization for two or more pharmacies, applicant must complete a Corporate Attachment form for each pharmacy.)***				
	3. How many pharmacies are owned by applicant ***(This includes pharmacy located within and outside Georgia, as well as those pharmacies for which the applicant is NOT seeking WIC authorization.)***				
C.	Is this application submitted as a result of a change in the pharmacy's location?	☐	Yes	☐	No
D.	Does this pharmacy location only sell special infant formula, including medical foods?	☐	Yes	☐	No

PART I - PHARMACY IDENTIFICATION

1.	Full Legal Name of Pharmacy:	Pharmacy Number: #
	Full Legal Name of Corporation (***if applicable***):	
	Registered Agent's Full Name (***if applicable***):	
	Pharmacy Manager's / Pharmacist's Full Name:	

CONTACT INFORMATION

2.	**PHARMACY INFORMATION:** Telephone Number: ( ) -	Fax Number: ( ) -

OWNER OR CORPORATE REPRESENTATIVE INFORMATION:
Business Telephone Number: ( ) -

Mobile Number: ( ) -

PHARMACY EMAIL ADDRESS (REQUIRED):

OWNER/CORPORATE EMAIL ADDRESS (REQUIRED):

PHYSICAL LOCATION

Street Address/Rural Route:

City: State: County: Zip +4

☐ Please check this box if the physical location is the same as the mailing address.

MAILING ADDRESS *(Complete if different from above address)*

Street Address

City | State | Zip + 4

3

a. Pharmacy License. Enter the license number and expiration date of the license and attach a copy of the license to this application.

b. Pharmacist License. Enter the license number and expiration date of the license and attach a copy of the license to this application.

c. Business License Number. Enter the license number and expiration date of the license and attach a copy of the business license to this application.

_____ Exp. Date. _____

_____ Exp. Date. _____

_____ Exp. Date. _____

TYPE OF BUSINESS – Check (√) Only One

4.

☐ Independent

☐ Chain

☐ Pharmacy License *(provide a copy of license)* License #

5.

a. Federal Employer Identification Number (**FEIN**): ____ — ____

Owner's SSN __ __ __ - __ __ - __ __ __ __

b. Secretary of State Control Number:

6.

a. Will this pharmacy be dependent upon receiving WIC authorization to remain sustainable? ☐ Yes ☐ No

	b. How was the pharmacy acquired? ☐ Sale ☐ Lease ***(Provide a copy of bill of sale or executed lease if applicable)*** From whom was the pharmacy acquired? _____ Date pharmacy will open(ed)?	What date was the pharmacy acquired? Month / Day / Year Month / Day / Year

7.	a. Are you related to previous owner(s) by blood or marriage? If yes, what is the relationship? _____	☐	Yes	☐	No
	b. Has the owner(s) ever owned a business(es) authorized by the Georgia WIC Program? If yes, list pharmacies below: (***Attach additional documentation, if necessary)***	☐	Yes	☐	No
	1. PHARMACY NAME	VENDOR NUMBER			
	2. PHARMACY NAME	VENDOR NUMBER			
	c. Has the previous owner(s) ever owned a pharmacy or pharmacies that was disqualified, terminated, or assessed a Civil Money Penalty while an active Georgia WIC vendor? ***(If yes, attach an explanation identifying the PHA and location, the specific penalty imposed, and the effective date of the penalty. Attach additional documentation, if necessary.)***	☐	Yes	☐	No
	d. Has the previous owner(s) ever owned a pharmacy or pharmacies that was disqualified, terminated, or assessed a Civil Money Penalty while an active WIC vendor in another state? ***(If yes, attach an explanation identifying the pharmacy and location, specific penalty imposed, and the effective date of the penalty. Attach additional documentation, if necessary.)***	☐	Yes	☐	No
	e. Has this pharmacy ever operated under another name in Georgia? If yes, list the pharmacy name(s), pharmacy location(s) and the dates of operation under that name. ***(Attach additional documentation, if necessary.)*** Name: _____ Address: _____ _____ Dates of Operation: _____	☐	Yes	☐	No

PART II – PHARMACY OWNERSHIP AND MANAGEMENT

1.	Type of Ownership – **Check (√) one** and attach relevant documentation (see instructions for details).				
☐	Sole proprietorship	☐	Privately owned corporation	☐	Government owned

☐	Partnership	☐	Publicly owned corporation	☐	Limited Liability Corporation

2. List the full name of ***every*** owner, partner, or corporate officer (e.g., President, Vice President, Secretary, etc.) who has at least a five percent (5%) financial interest in the business. Attach additional sheets, if needed. Shortened versions of a name, including nicknames and initials, are not acceptable. If you indicated in Question #10 that the business is either a publicly owned corporation or government owned, **skip this section.**

	First Name	Middle Name	Last Name	Social Security Number
2a.	1.			
	Date of Birth / /			
	First Name	**Middle Name**	**Last Name**	**Social Security Number**
	2.			
	Date of Birth / /			
	First Name	**Middle Name**	**Last Name**	**Social Security Number**
	3.			
	Date of Birth / /			
	First Name	**Middle Name**	**Last Name**	**Social Security Number**
	4.			
	Date of Birth / /			

2b.	Name of Registered Agent:	
	Address of Registered Agent:	

PART III – PHARMACY HISTORY

1.	**Prior WIC Applications.** Including this pharmacy, have any of the current owner(s), partner(s), or corporate officer(s) previously applied for vendor authorization to the Georgia WIC Program? ***(If yes, attach an explanation identifying the individual, the pharmacy name and location, the date the application was submitted, and whether the application was denied or approved.)***	☐ Yes ☐ No

2a.	**Ownership History** Including this pharmacy, have any of the current owner(s), partner(s), or corporate officer(s) ever owned or managed a pharmacy/business that was disqualified, terminated, or assessed a Civil Money Penalty, while an active Georgia WIC vendor? ***(If yes, attach an explanation identifying the owner, the pharmacy name and location, pharmacy vendor number, the basis for the sanction imposed and the effective date of the sanction).***	☐ Yes ☐ No
2b.	Have any of the current owner(s), partner(s), or corporate officer(s) ever been convicted of or had 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? ***(If yes, attach an explanation identifying the person, the date of the judgment and the nature of the violation).***	☐ Yes ☐ No
2c.	Do any of the current owner(s), partner(s), or corporate officer(s) ***currently*** own or have any involvement with other WIC approved pharmacies, either in the State of Georgia or outside of Georgia? ***(If yes, attach an explanation identifying the person(s) and the pharmacy or pharmacies owned, including the pharmacy name(s), address(es) and vendor number(s).)***	☐ Yes ☐ No
2d.	Have any of the current owner(s), partner(s), or corporate officer(s) ***previously*** owned, or had any involvement with other WIC approved pharmacies, either in the State of Georgia or outside of Georgia? ***(If yes, attach an explanation identifying the person(s) and the pharmacy or pharmacies owned, including the pharmacy name(s), address(es) and vendor number(s).)***	☐ Yes ☐ No
2e.	Identify any relatives, who are related by blood or marriage, who own/have owned, or have current or previous involvement with a WIC approved pharmacy either in the State of Georgia or outside of Georgia. ***(Attach an explanation, identifying the name(s) of the individual(s), the name of the individual to whom they are related, the nature of the relationship, the pharmacy name(s), the pharmacy, or pharmacies address(es) and the pharmacy's vendor number(s).)***	
2f.	Identify any relatives, related by blood or marriage, who has ever owned or managed a business that was disqualified, assessed a Civil Money Penalty, or terminated from the Georgia WIC Program. ***(Attach an explanation, identifying the name of the owner/officer/manager, the name of the family member, the nature of their relationship, the pharmacy name and address, the pharmacy's vendor number, the specific sanction imposed and the effective date of the sanction).***	
2g.	Identify any affiliates who own/have owned, or who have current or previous involvement with a WIC approved pharmacy or pharmacies, either in the State of Georgia or outside of Georgia. ***(Attach an explanation, identifying the name of the owner/officer/manager, the name of the relative, the nature of their relationship, the pharmacy name and address, and the pharmacy's vendor number. For corporate vendors, this includes subsidiaries of this business or parent companies for which this pharmacy is a subsidiary).***	
2h.	Identify any affiliate who ever owned or managed a business that was disqualified, assessed a Civil Money Penalty, or terminated from the Georgia WIC Program. ***(Attach an explanation, identifying the owner/officer/manager, the name of the business affiliate, the pharmacy name and address, the pharmacy's vendor number, the nature of the affiliation, the specific sanction imposed and the effective date of the sanction).***	

PART IV. A. – OPERATIONS AND SALES

HOURS OF BUSINESS

1.	☐ Check (√) here if opened 24 hours each day		Wednesday	a.m.	p.m./a.m.
	Sunday	a.m. p.m./a.m.	Thursday	a.m.	p.m./a.m.
	Monday	a.m. p.m./a.m.	Friday	a.m.	p.m./a.m.
	Tuesday	a.m. p.m./a.m.	Saturday	a.m.	p.m./a.m.

POINT-OF-SALE AND eWIC INFORMATION

2. The GA WIC Program processes eWIC transactions and reimburses its Vendors through the use of the Georgia eWIC Card and electronic benefits transfer (EBT) processing. Provide the information requested below. Please be as accurate as possible.

a.	**Total** Number of Registers in Store (Including U-Scans):		f.	If integrated, who is your Third-Party Processor (TPP)?	
b.	Number of Registers with Scanning Devices:			☐ FISERV ☐ World Pay ☐ First Data ☐ Other: _____	
c.	Number of Lanes		g.	Who is your Value-added Reseller (if applicable)?	Name:
d.	Does the store have an electronic cash register and point-of-sale (ECR/POS) system that is *eWIC*-capable?	☐ Yes ☐ No	h.	Please check all forms of payment your pharmacy can accept. **Cash** ☐ **EBT** ☐ **Debit** ☐ **Credit** ☐ **Checks** ☐	
e.	Identify the Point-of-sale (POS) system type:	☐ Integrated ☐ Stand-beside device			

BANKING INFORMATION

3. Enter information pertaining to where the pharmacy will deposit all WIC food instruments and cash value vouchers. If the applicant is a Corporate Vendor, enter the specific bank information for each pharmacy for which WIC authorization is sought on the Corporate Vendor, enter the specific bank information for each pharmacy for which WIC authorization is sought on the Corporate Attachment Form.

1.	Bank name	
	STREET NUMBER & NAME	
	CITY, STATE, AND ZIP+4	
	TELEPHONE NUMBER (INCLUDING AREA CODE)	
2.	**Business Routing and Account Number**	
	ROUTING NUMBER	
	ACCOUNT NUMBER	

PART V - INVENTORY

1.	a. Was all infant formula that will be used to redeem WIC food instruments (paper voucher or eWIC card) purchased from suppliers listed on the Approved Infant Formula Supplier list? ***(Visit http://dph.georgia.gov/vendor-information and select Approved Infant Formula Suppliers)***	☐ Yes ☐ No

Note: Records of all infant formula purchases must be maintained according to the terms of the WIC Vendor Agreement.

b. If yes, indicate the name of the supplier, address, city, state, and zip. ***(Attach additional documentation as necessary.)***

Supplier		
Address		
City	State	Zip
Supplier		
Address		
City	State	Zip

WIC Infant Formula/ Medical Foods Information

Authorized WIC pharmacies are only permitted to redeem special infant formulas and medical foods as specified on the Georgia WIC vendor website (https://dph.georgia.gov/WIC/wic-formula-resources).

PART VI – STATEMENTS AND CERTIFICATION

PRIVACY ACT STATEMENT – The solicitation of the information requested in this application is authorized by Title 7 of the Code of Federal Regulations, Part 246, Subpart E (7 CFR § 246.12), which governs the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program). The provision of this information is voluntary and will be used to determine eligibility of a pharmacy to participate in the Georgia WIC Program as an authorized vendor; to routinely monitor authorized vendors for compliance with Georgia WIC Program's policies and rules; for audit and enforcement of WIC Program regulations, policies, and rules; and for program management. Failure to provide this information may result in the denial of authorization for new vendor applicants or termination of authorized vendors from the WIC Program.

WARNING STATEMENT – Information in this application will be verified with other agencies. Vendor authorization may be denied or terminated if it is determined that the vendor applicant provided false statements, made false representations, or used any false writing or documentation in connection with this application. Authorization may be denied or terminated if the vendor applicant violates any laws or regulations issued by Federal, State, or local programs, including Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamps Program).

CERTIFICATION AND SIGNATURE OF OWNER OR AUTHORIZED REPRESENTATIVE

1. I have the authority to apply for Georgia WIC Program vendor authorization on behalf of the applying pharmacy.
2. I have the authority to enter into a WIC Vendor Agreement between the applying pharmacy and the Georgia Department of Public Health's Georgia WIC Program.
3. I will timely notify the Georgia WIC Program of any changes made to the operation, management, and ownership of the applying pharmacy upon authorization as required by the Georgia WIC Program.
4. I affirm that all statements made, including financial/pricing information provided, in this application are true and accurate.

5. I read and understand the penalties in the warning statement above. I understand that false or incomplete information provided to the Georgia WIC Program or violation of the terms of the WIC Vendor Agreement shall result in termination of that agreement.
6. I understand that the ownership and management of this pharmacy will be responsible for understanding the requirements, policies, and procedures appearing in the WIC Vendor Handbook, which is considered part of the WIC Vendor Agreement.
7. I authorize Georgia WIC Program to investigate my background and that of every owner, partner, or corporate officer with a financial interest in the applying pharmacy for purposes of evaluating my vendor application. I understand that I may withhold my permission and that in such cases, no background checks will be done, and my vendor application will not be processed further.

SIGNATURE: _____ DATE: _____
(No initials)

PRINT NAME: _____
(No initials)

TITLE: _____

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Return application to:
DO NOT FAX
DO NOT HAND DELIVER

Georgia WIC Program
Office of Vendor Management
2 Peachtree Street, NW
10th Floor
Atlanta, Georgia 30303-3142
Toll-free:1-866-814-5468

INSTRUCTIONS FOR COMPLETING THE VENDOR APPLICATION

A. Check the appropriate box to indicate if the application is a new application for authorization, a re-authorization application, or if this application is associated with the following reasons:
   1. Change of ownership
   2. Change of pharmacy or corporate name/address
   3. Addition of new pharmacies by a corporate vendor.

   If the application is a re-authorization application or an application associated with the change of ownership, pharmacy/corporate name, or address, please enter the current vendor number in the space provided. If the application is for addition of new pharmacies by a corporate vendor, attach a list of existing WIC authorized pharmacies owned by the corporate vendor.

B.1. Answer "yes" or "no" if the applying pharmacy is owned by a corporate entity.

B.2. Enter the total number of pharmacy locations for which the applicant is seeking authorization. If the applicant is seeking authorization for two or more pharmacies, a Corporate Attachment Form must be completed for each pharmacy.

B.3. Enter the total number of pharmacy locations owned by the applicant. This includes those pharmacies that are located within and outside Georgia, as well as those pharmacies that are not WIC authorized and those pharmacies for which the applicant is NOT seeking WIC authorization.

C. Answer "yes" or "no" if the application is being submitted as a result of a change in the pharmacy's location.

D. Answer "yes" or "no" if the pharmacy location sells exempt (non-contract) or special infant formula, including medical foods, **only**. **Please note: ONLY LICENSED PHARMACIES SEEKING WIC AUTHORIZATION ARE AUTHORIZED TO REDEEM SUCH PRODUCTS**.

PART I - PHARMACY IDENTIFICATION

1. **FULL LEGAL NAME OF PHARMACY**. Enter the name of the pharmacy. Include the pharmacy number, if applicable. The WIC program defines a Corporate Vendor as an authorized vendor that is owned by a corporate entity. **If applying for WIC authorization for multiple pharmacies that are owned by a corporate entity, enter "CA" (Corporate Attachment Form) on this line and complete a Corporate Attachment form for each pharmacy.**

   FULL LEGAL NAME OF CORPORATION (if applicable). Enter the legal name of the corporation, limited liability company, or partnership that owns the pharmacy for which you

seek authorization. If the corporate entity has a division or department that is dedicated to handling WIC issues, include the name of the division or department after the name.

REGISTERED AGENT'S NAME. Enter the name of the person designated to serve as the registered agent for the corporate entity, limited liability company, or partnership.

MANAGER'S NAME. Enter the name of the person who is responsible for this pharmacy location. For Corporate Vendors enter "CA", and provide this information in the section, "Pharmacy Contact and Title", of the Corporate Attachment form for each pharmacy. Also, enter the email address for the manager for each pharmacy on the Corporate Attachment form.

2. **CONTACT INFORMATION**

PHARMACY- TELEPHONE NUMBER. Enter the main telephone number of the pharmacy. **DO NOT LIST MOBILE TELEPHONE NUMBERS.** For Corporate Vendors, enter "CA" and provide this information for each pharmacy on the Corporate Attachment Form.

FAX NUMBER. Enter the fax number for the pharmacy. For Corporate Vendors, enter the main fax number for the corporation's home office. If the corporation has a division or department dedicated to handling WIC issues, enter the fax number of the division or department.

OWNER OR CORPORATE REPRESENTATIVE- BUSINESS TELEPHONE NUMBER. Enter the primary telephone number for the owner/corporate representative (ex. corporation's home office). If the corporation has a division or department that is dedicated to handling WIC issues, enter the telephone number of the division or department. Include an extension, if applicable.

OWNER OR CORPORATE REPRESENTATIVE- MOBILE TELEPHONE NUMBER. Enter the mobile telephone number for the owner and corporate representative, if applicable.

E-MAIL ADDRESS. Enter the e-mail address for the point of contact for the pharmacy. For owners /corporate representative, enter the main e-mail address for the owner or corporation's home office on the application. For Corporate Vendors, please include on the Corporate Attachment form (where indicated) the email address for the designated point of contact for each pharmacy.

PHYSICAL LOCATION. Enter the street name and number, city, county, state, and zip code for the pharmacy's physical location. For Corporate Vendors, enter "CA" and provide this information for each pharmacy on the Corporate Attachment Form. **DO NOT enter a post office box address.** Also, attach a copy of the lease for the pharmacy location for a minimum period of three years or attach a copy of the deed for the pharmacy location. Check the box if the physical location is the same as the mailing address.

MAILING ADDRESS. If the mailing address for the pharmacy is different from its physical location, provide the mailing address here. For Corporate Vendors, enter the mailing address of the corporation's home office and enter the mailing address for each pharmacy location on the Corporate Attachment Form. If the corporation has a division or department dedicated to handling WIC issues, include the floor/suite of the department or division.

3. a. **PHARMACY LICENSE NUMBER**. Enter the Pharmacy License Number that is issued for the pharmacy location name and attach a copy of the license with the application. Corporate Vendors must enter "CA" and provide this information on the Corporate Attachment form for each applying pharmacy.

   b. **PHARMACIST LICENSE**. Enter the pharmacist license number and its expiration date and attach a copy of the pharmacist license with the application. Corporate Vendors must enter "CA" and provide this information on the Corporate Attachment form for each applying pharmacy.

   c. **BUSINESS LICENSE**. Enter the business license number and its expiration date and attach a copy of the business license to the application. Corporate Vendors must enter "CA" and provide this information on the Corporate Attachment form for each applying pharmacy.

4. **TYPE OF BUSINESS**. Check the box that best describes the pharmacy. The following are brief definitions for each type of business entity listed on the vendor authorization application:

   - **Independent -** A pharmacy that is independently owned by a person or group.
   - **Chain -** An individual or organization, whether corporate or non-corporate, that owns 20 or more locations within and outside the State of Georgia.
   - **Pharmacy -** A pharmacy that is licensed by the Georgia Board of Pharmacy. A pharmacy may participate in WIC to redeem exempt and/or special infant formulas, including special medical foods, ONLY. Enter the pharmacy license number and attach a copy of the license to the application.

5. a. **FEDERAL EMPLOYER IDENTIFICATION NUMBER.** Enter the Federal Employer Identification Number (FEIN) assigned to the pharmacy by the Internal Revenue Service (IRS). If the owner is a sole proprietor and does not have a FEIN, enter the owner's Social Security Number (SSN). For Corporate Vendors, enter "CA", and include the FEIN on the Corporate Attachment Form for each applying pharmacy.

   b. **SOS CONTROL NUMBER**. If the applicant's business is registered with the Secretary of State's Corporations' Division, enter the control number that was assigned to the business. If the pharmacy does not have a control number, enter "N/A".

6. **MINIMUM INVENTORY AND OPENING DATE**.

   a. Answer "yes" or "no" whether this pharmacy is dependent upon WIC authorization to sustain its business operation.

   b. **ACQUISITION DATE**. If the pharmacy was purchased from a prior owner, provide the name of the prior owner, the date the purchase occurred, and a copy of the bill of sale or closing documents. If the pharmacy is leased, attach a copy of the lease agreement. **A lease agreement must be for a minimum of three years**.

   c. **MINIMUM INVENTORY** - Enter the specific month, day, and year that **ALL** required quantity and variety of WIC-approved foods and non-WIC food items (including perishables) will be in stock and ready for inspection. To access the minimum inventory requirements, visit http://dph.georgia.gov/vendor-information and select "WIC Minimum Inventory Requirements". If the pharmacy is a pharmacy or military commissary, or if the pharmacy is applying for reauthorization, enter "N/A".

7. **PREVIOUS OWNER'S HISTORY**.

   a. **RELATIONSHIP TO OWNER**. Check "yes" or "no" to indicate if the pharmacy's current owner(s), partner(s), or corporate officer(s) are related to the previous owner(s) by blood or marriage. If yes, specify the individual and the nature of the relationship.

   b. **OTHER WIC-AUTHORIZED PHARMACIES**. Check "yes" or "no" to indicate if the prior owner(s) own other WIC authorized pharmacies. If yes, enter each pharmacy's name and the WIC vendor number(s) in the space provided. Attach additional documentation if necessary.

   c. **PREVIOUS OWNER'S GEORGIA WIC SANCTION HISTORY**. Check "yes" or "no" if the previous owner(s) ever owned a pharmacy(ies) that was disqualified, terminated, or assessed a Civil Money Penalty while an active Georgia WIC vendor. If yes, attach an explanation identifying the pharmacy, specific penalty imposed, and the effective date of the penalty.

   d. **PREVIOUS OWNER'S WIC SANCTION HISTORY FROM ANOTHER STATE**. Check "yes" or "no" if the previous owner(s) ever owned a pharmacy(ies) that was disqualified, terminated, or assessed a Civil Money Penalty while an active WIC vendor in another State. If yes, attach an explanation identifying the pharmacy, the specific penalty imposed, and the effective date of the penalty.

   e. **OPERATION UNDER ANOTHER NAME**. Check "yes" or "no" to indicate if the pharmacy has ever operated under another name. If yes, list the pharmacy name(s), pharmacy location(s) and the dates of operation under that name.

PART II – PHARMACY OWNERSHIP AND MANAGEMENT

1. **TYPE OF OWNERSHIP**. Check the type of business entity structure that best describes how your pharmacy is owned:

   - **Sole proprietorship.** A business that is owned by a single individual.
   - **Partnership.** A business that is owned by two or more individuals.
   - **Privately-owned corporation.** For purposes of this application, a privately-owned corporation has shares or stock that are not traded on a stock exchange, nor are available for purchase by the general public.
   - **Publicly owned corporation.** For purposes of this application, a publicly owned corporation has shares or stocks that are traded on a stock exchange and are available for purchase by the general public.
   - **Government owned entity.** A business entity that may include commissaries, pharmacies, or clinics that are owned and operated by county, state, or federal government agencies.
   - **Limited Liability Company (LLC).** A business combining both corporations and partnerships in that the business is required to register with the Secretary of State but does not have the same filing and record maintenance requirements as a corporation.

You must attach all documentation to verify the type of business entity you selected. Documentation may include the following:

Type of Business Structure	Documentation Required
• Sole proprietorship	N/A
• Partnership	Certificate of Limited Partnership
• Corporation	Articles of Incorporation
• Government-owned Entity	Any license and/or certificate required
• Limited Liability Company	Articles of Organization

2. **OWNERSHIP/FINANCIAL INTEREST IN PHARMACY**.

   a. Enter the full name, Social Security number, and date of birth for each person who has a 5% or greater ownership/financial interest in the pharmacy. Attach additional documentation, if necessary**. Provide the full name of each individual and his/her social security number and date of birth. Do not complete this section if the pharmacy is government owned or a publicly owned corporation.**

   b. Registered Agent. Enter full name and mailing address of the person designated to serve as the registered agent for the corporate entity, limited liability company, or partnership.

PART III – PHARMACY HISTORY

1. **PRIOR WIC APPLICATION SUBMISSION(S**). Check "yes" or "no" to indicate if the current owner(s), partner(s), or corporate officer(s) have ever applied for vendor authorization to the Georgia WIC program on behalf of this pharmacy and/or other pharmacy(ies). If yes, attach an explanation identifying the individual, the pharmacy name and location, the date the application was submitted, and whether the application was denied or approved.

2. **CURRENT OWNER'S HISTORY**

   a. **PREVIOUS GEORGIA WIC SANCTION HISTORY**. Check "yes" or "no" to indicate if the current owner(s), partner(s), or corporate officer(s) have ever owned or managed a pharmacy that was disqualified, terminated, or assessed a Civil Money Penalty while an active Georgia WIC vendor. If yes, attach an explanation, identifying the individual, the name and location, pharmacy vendor number, the basis for the sanction imposed and the effective date of the sanction.

   b. **CONVICTIONS/JUDGMENTS**. Check "yes" or "no" to indicate if the current owner(s), partner(s), or corporate officer(s) ever had a civil judgment involving 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. If yes, attach an explanation identifying the person, the date of the judgment and nature of the violation.

   c. **CURRENT WIC INVOLVEMENT**. Check "yes" or "no" to indicate if the current owner(s), partner(s), or corporate officer(s) currently own or are otherwise involved

with other WIC-approved pharmacies either in the State of Georgia or outside of Georgia. If yes, attach a list identifying the pharmacy the name of the current owner(s), partner(s), or corporate officer(s), the pharmacy name and address, and the pharmacy's vendor number.

d. **PRIOR WIC INVOLVEMENT**. Check "yes" or "no" to indicate if the current owner(s), partner(s), or corporate officer(s) previously owned, or were otherwise involved with other WIC-approved pharmacies either in the State of Georgia or outside of Georgia. If yes, attach a list that includes the name of the current owner(s), partner(s), or corporate officer(s), the pharmacy name and address of the pharmacy(ies), and the pharmacy's vendor number.

e. **PRIOR OR CURRENT WIC INVOLVEMENT BY RELATIVES**. Identify whether the current owner(s), partner(s), or corporate officer(s) have relatives, who are related by blood or marriage, who have currently or previously owned, or have otherwise had involvement with WIC-approved pharmacies in the State of Georgia or outside of Georgia. If yes, attach a list that includes the name of the owner(s), partner(s), or corporate officer(s), the name of the relative, the nature of their relationship, the pharmacy name and address, and the pharmacy's vendor number.

f. **RELATIVES WHO HAVE RECEIVED WIC PENALTIES**. Identify whether the current owner(s), partner(s), or corporate officer(s) has a relative(s), related by blood or marriage, who currently or previous owned or has otherwise had involvement with a WIC-approved pharmacy(ies) that were disqualified from the Program, terminated from the Program, or were assessed a Civil Money Penalty. If yes, attach an explanation identifying the name of the owner(s), partner(s), or corporate officer(s), the name of the family member, the nature of their relationship, the pharmacy name and address, the pharmacy's vendor number, the specific sanction imposed and the effective date of the sanction.

g. **PRIOR OR CURRENT WIC INVOLVEMENT BY BUSINESS AFFILIATES**. Identify whether the current owner(s), partner(s), or corporate officer(s) have business affiliates who have currently or previously owned, or have otherwise had involvement with, WIC-approved pharmacies in the State of Georgia or outside of Georgia. If yes, attach a list that includes the name of the owner(s), partner(s), or corporate officer(s), the name of the relative, the nature of their relationship, the pharmacy name and address, and the pharmacy's vendor number. For corporate vendors, this includes subsidiaries of this business or parent companies for which this pharmacy is a subsidiary.

h. **BUSINESS AFFILIATES WHO HAVE RECEIVED WIC PENALTIES**. Identify whether the current owner(s), partner(s), or corporate officer(s) has business affiliates, who currently or previously owned or have otherwise had involvement with WIC-approved pharmacies that were disqualified from the Georgia WIC Program, terminated from the Georgia WIC Program, or were assessed a Civil Money Penalty. If yes, attach a list that includes the name of the owner(s), partner(s), or corporate officer(s), the name of the business affiliate, the pharmacy name and address, the pharmacy's vendor number, the nature of the affiliation, the specific sanction imposed and the effective date of the sanction.

PART IV. A. – OPERATIONS AND SALES

1. **HOURS OF BUSINESS**. Enter the hours the pharmacy is actually open for business each day. For Corporate Vendors, enter "CA" and provide the specific hours of operation on the Corporate Attachment form for each applying pharmacy.

2. **WIC POINT-OF-SALE & eWIC INFORMATION**. Enter the required information (a-h) pertaining to the method(s) used by the store to process food transactions. For Corporate Vendors, enter "CA" and provide this information on the Corporate Attachment Form for each applying store.

3. **BANK INFORMATION**. Enter the name and contact information of the banking institution where all WIC food instruments, and cash value vouchers will be deposited. The routing number and account number for that account must also be listed. For Corporate Vendors, enter "CA" and provide this information on the Corporate Attachment Form for each applying pharmacy. NOTE: The banking information entered MUST match the banking information entered on the ACH form. Further, if the pharmacy's banking information changes, Georgia WIC must be notified within two business days of the change.

PART V - INVENTORY

This section must be completed, and all documentation attached that supports the information entered (e.g., infant formula invoice). For Corporate Vendors, enter "CA" and provide the requested information and supporting documentation on the Corporate Attachment Form for each applying pharmacy.

1. **INFANT FORMULA SUPPLIER**. All applicants are required to purchase infant formula ONLY from suppliers who are included on the Georgia WIC Program's Approved Infant Formula Supplier List. For a comprehensive list of all approved suppliers, visit **http://dph.georgia.gov/vendor-information** and select the link, "Approved Infant Formula Suppliers".

   a. Answer "yes" or "no" and attach all invoices documenting the purchase(s) of contract formula made in preparation for the pre-authorization visit. For Corporate Vendors, enter "CA" and provide this information on the Corporate Attachment Form for each applying pharmacy.

   b. Enter the name and address of each infant formula supplier from whom the pharmacy purchases contract infant formula inventory.

2. **WIC INFANT FORMULA/ MEDICAL FOODS INFORMATION**. Authorized WIC pharmacies are only permitted to redeem special infant formulas and medical foods as specified on the Georgia WIC vendor website (https://dph.georgia.gov/WIC/wic-formula-resources).

PART VI – STATEMENTS AND CERTIFICATION

Applicants must **review and sign** the Privacy Act Statement, Warning Statement and Certification. **An owner or authorized representative must sign, print name, provide his/her title, and date the application. Initials or a shortened version of a name are not acceptable.**