Application

Address Confidentiality Program (ACP)

Instructions

NYS Department of State
Address Confidentiality Program
P.O. Box 1110
Albany, NY 12201-1110
Phone: (518) 474-7306
Toll Free: (855) 350-4595
Fax: (518) 474-0709
Email: ACP@dos.ny.gov
Web:www.dos.ny.gov/address-confidentiality

A program participant must complete this application in order to become a participant in the Address Confidentiality Program. All applicants should review the instructions below to ensure they understand how to properly complete the application form.

Section 1 - Participant Information

Primary Participant Name

The applicant may be an adult who is a victim of domestic violence, stalking, sexual offense, and/or human trafficking who fears for their safety and has left their residence because of such fear.

The applicant may be a reproductive health care services provider, employee, volunteer, patient, or immediate family member of a reproductive health care services provider who fears for their safety (this person need not have left their residence because of such fear).

The applicant may also be the parent or legal guardian applying on behalf of a minor (person under 18 years of age) or incapacitated person and must have legal authority to act on the person's behalf. The applicant must check the appropriate box in Section 3 that indicates whether they are applying on their own behalf or on behalf of a minor or incapacitated person and sign the affirmation. The program participant should include his/her full legal name and date of birth.

Please list any other names by which you are now or have formerly been known.

If, for safety reasons you would like your mail forwarded to you under a different name, please contact our office at (855) 350-4595 and we will assist you with this request.

Other Participants

This section may include other members of the same household as the primary participant who need to participate in the ACP in order to keep the primary participant safe. It may also include a minor, an incapacitated person, or an adult living in the household who consents to participate in the program. Other adults in the primary participant's household must also complete the affidavit contained within Section 4.

The applicant must also indicate whether the other household members are minors, incapacitated persons or other adults living in the household. The full legal name and date of birth of each household member must be provided.

Please note that once a minor becomes an adult (age 18), s/he must complete a new application and sign Section 4 in order to continue participating in the ACP. If this new adult household member fails to submit this new application, his/her name will be removed from the program.

Copies of this page can be made if additional participants need to be added.

Primary Participant's Actual Address

This is the address where the primary participant lives. Applicants must complete this section, including the county name. The address cannot be a Post Office Box. Participation in the ACP Program is limited to New York State residents. The primary participant must provide a phone number so that the ACP Program can reach him or her. A safe alternative phone number should also be provided. ACP recommends that the participant indicate the best time of the day to receive calls.

Primary Participant's Mailing Address

This is the address where the primary participant would like his/her mail delivered. This may be left blank if it is the same as the actual address. The ACP can send mail to a post office box or to an address other than the actual address.

If this address changes, please contact the Address Confidentiality Program for instructions on changing or use the ACP Change/Withdraw Notice DOS-1931-f-a https://www.dos.ny.gov/forms/acp/1931-f-l-a.pdf . Do not file a change of address with the US Post Office.

Email Address: Please indicate your email address as another method of contact for ACP staff.

ACP Identification Number

This is the unique identification number issued to each primary ACP participant. If the program participant is new to the program, he or she will receive an ACP number in the mail. If an application involves a participant that already has been issued an identification number, this ACP number should be included on the application.

(instructions continued on next page)

Instructions for Application

Address Confidentiality Program (ACP) continued

Security Word

The program participant should provide a secret word on the application to create a secure way to make any future changes to the participant's record. This should prevent unauthorized individuals from making changes to the record. Please keep it in a safe spot.

Program participants should provide a hint to help them remember the secret word. If the program participant cannot remember the secret word when completing a change form, s/he can call the ACP office and a staff member will provide the hint to help remember the word.

Section 2 - Checklist for Program Participant

The applicant should thoroughly read and understand each checklist item in this section. An application assistance provider can explain the meaning of each of the statements in this section. The applicant should initial each item on the checklist, which confirms that he or she understands and agrees with each item.

Section 3 - Program Participant Affidavit

The applicant should check the corresponding box that indicates whether s/he is completing the application on his/her own behalf or completing the application as legal guardian of the program participant indicated on the application. An applicant must have legal authority to act on behalf of any minor and/or incapacitated person included on the application.

The program participant or legal guardian must sign his or her name on the line affirming that all the information provided on the application is true and correct. By signing the application, the participant also affirms that s/he understands how the ACP works and the requirements of being enrolled in the program.

Section 4 - Other Adult Member of the Household Affidavit

Each adult member of a household who wishes to participate in the ACP should check the box affirming s/he is a member of the household and wishes to participate in the ACP. This form may be copied and filled out by each participating adult member.

Each adult member must sign his or her name on the line affirming that all the information provided about them on the application is true and correct. By signing the application, adult participants affirm that they understand how the ACP works and the requirements of being enrolled in the program.

Section 5 - Application Assistance Provider (if applicable)

If an application assistance provider explains the Address Confidentiality Program to the applicant and helps complete the forms, the application should include the name of the agency, the corresponding agency code, the name of the agency contact person and the agency phone number.

If an applicant is applying without the assistance of an agency, completion of this section is not necessary.

Completed application forms should be sent to the address indicated on the application.

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Albany, NY 12201-1110
Phone: (518) 474-7306
Toll Free: (855) 350-4595
Fax: (518) 474-0709
Email: ACP@dos.ny.gov
Web:www.dos.ny.gov/address-confidentiality

Read instructions carefully before completing this application. **Please PRINT or TYPE responses in ink.**

SECTION 1: Participant Information

Participation in the ACP Program is limited to New York State residents.

Primary Participant Name (First, Middle, Last) **ACP Identification Number** (if existing record) _____

First Name _____ Middle Name _____ Last Name _____ **Date of Birth** (MM/DD/YYYY) _____

Any other names you are now or have formerly been known as: _____

I am a New York State resident: **Yes** ☐ **No** ☐

I am victim of ☐ **Domestic Violence** ☐ **Stalking** ☐ **Sexual Offense** ☐ **Human Trafficking**

☐ **I am a reproductive health care services provider employee, volunteer, patient, or immediate family member of a reproductive health care services provider.**

Other Participants (First, Middle, Last) -- You may make copies of this page and attach if you have additional participants.

First Name	Middle Name	Last Name	Date of Birth (MM/DD/YYYY)	(Minor/Incapacitated/Adult living in Household)

Primary Participant's Actual Address (The address where the applicant actually lives) *required to participate in program.

Address 1: _____

Address 2: _____

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

Day Phone: _____ Evening Phone: _____ Safe Alternate Phone: _____ Best Time to Call: _____ ☐ AM ☐ PM

Primary Participant's Mailing Address * (The address where ACP will send the applicant's mail if different than above address)

Address 1: _____

Address 2: _____

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

Email Address: _____

- If this address changes, please contact the Address Confidentiality Program for instructions on changing or use the ACP Change/Withdraw Notice DOS-1931-f-a https://www.dos.ny.gov/forms/acp/1931-f-l-a.pdf . Do not file a change of address with the US Post Office.

Have you ever participated in New York's Address Confidentiality Program? ☐ Yes ☐ No

If Yes, please provide previous ACP Identification Number # _____

Security Word - This secret word will be used for all future changes to your record - It is important to keep in a safe spot.

Provide your secret word: _____

Provide a hint that will help you remember this secret word: _____

(form continued with Section 2 on next page)

SECTION 2: Checklist for Program Participant - Please initial each item.

___ I understand that the ACP is a mail forwarding service only and that my mail will first come to the program's P.O. Box address in Albany before it is forwarded to me. This means it will take longer for me to receive my mail, including legal mail that may contain time sensitive material. I also understand that ACP will only forward first-class mail and legal documents to me and WILL NOT forward magazines, catalogs, packages or junk mail unless clearly identifiable as pharmaceuticals or clearly indicates that it is sent by a government agency.

___ I understand that it is my responsibility to let state and local government employees know that I want to use the ACP substitute address and that I will need to show them my ACP I.D. card. I also understand that if I give a government agency my actual address, that agency is under no obligation to keep my information confidential.

___ I understand that my mail may not be forwarded to me if it is sent to a name other than the name on record at ACP. I also understand that if I complete an application form using a name other than my legal name it could result in denial of ACP privileges at certain agencies if a legal name is required to access their services.

___ I understand that private companies (such as insurance, telephone, utility, etc.) are not obligated to use the ACP substitute address and may require an actual residential street address.

___ I understand that the ACP is prohibited by law from releasing my actual address to a third party. However, the ACP may release my actual address if ordered by the courts to do so, or if requested by a law enforcement agency for legitimate law enforcement purposes.

___ I understand that I will be cancelled from the program if I provided false information on my ACP application. I also understand that the ACP will cancel my participation if I change my name or address and do not notify the program within 14 days, or if mail is returned non-deliverable.

SECTION 3: Program Participant Affidavit - Please check one of the following.

☐ I affirm that I, as the program participant, am a victim of domestic violence, stalking, sexual offense, and/or human trafficking. I have left my residence because of such violence and I fear for my safety and/or my children's safety. I have legal authority to act on behalf of all minors and/or incapacitated persons included on this application.

☐ I affirm that I am the legal guardian of the program participant indicated on this application and I am acting on behalf of a minor or incapacitated person who is a victim of domestic violence, stalking, sexual offense, and/or human trafficking who has left their residence because of such violence and they fear for their safety. I have legal authority to act on behalf of this minor and/or incapacitated persons included on this application.

☐ I affirm that I, as the program participant, am a reproductive health care services provider, employee, volunteer, patient, or immediate family member of a reproductive health care services provider who fears for his/her safety or the safety of an immediate family member.

☐ I affirm that I am the legal guardian of the program participant (s) indicated on this application who is a minor or incapacitated person on whose behalf this application is being made. Such person is a reproductive health care services provider, employee, volunteer, patient, or immediate family member of a reproductive health care services provider and I fear for their safety.

Affirmation of Applicant:

I hereby affirm under penalties of perjury that all information provided on this application is true and correct. I understand that I will only receive first class, registered and certified mail through this program. The ACP does not forward magazines, packages or junk mail. I understand that moving from the residential address given on this application or changing my mailing address without first notifying the ACP may result in the cancellation of my participation in the ACP. I hereby designate the Secretary of State as my agent for service of process and receipt of mail.

Signature of Applicant _____ Print Name _____ Date _____

SECTION 4: Other Adult Member of the Household Affidavit - Please check the following.

This section should be completed by any adult member of the same household as the primary participant.
Make a copy of this page and attach for any additional adult member of the household.

☐ I affirm that I am an adult member of the same household as the program participant contained on this application and consent to participate in the ACP.

Affirmation of Applicant:

I hereby affirm under penalties of perjury that all information provided on this application is true and correct to the best of my knowledge. I understand that I will only receive first class, registered and certified mail through this program. The ACP does not forward magazines, packages or junk mail. I hereby designate the Secretary of State as my agent for service of process and receipt of mail.

Signature of Applicant _____ Print Name _____ Date _____

SECTION 5: Application Assistance Provider - (If applicable)

Agency Name: _____ Agency Code: _____

Agency Contact Name: _____ Phone Number: _____

Signature _____

Please return the completed application to:
NYS Department of State
Address Confidentiality Program
P.O. Box 1110, Albany, NY 12201-1110
OR return to ACP via Fax at: (518) 474-0709