

Safe at Home: Address Confidentiality Program (ACP) Application



Secretary of the State of Connecticut
165 Capitol Avenue
P.O. Box 150469
Hartford, CT 06115-0469

For ACP Use

Cert Number: _____
HHI Number: _____
Card Issue Date: ____/____/____
Expiration Date: ____/____/____



Primary Applicant Information

Were you previously enrolled in the Connecticut Address Confidentiality Program?

☐ Yes ☐ No

First: _____ Middle: _____ Last: _____

Full Legal Name (first and last required)

Other names used on Applicant's mail (optional)

_____ mm: _____ dd: _____ yyyy: _____

Phone Number (required)

Alternate Phone Number (optional)

Date of Birth (required)

Email Address (required)

Gender: ☐ Female ☐ Male ☐ Other

Primary Language: ☐ English ☐ Español ☐ Other

Best Contact Method: ☐ Phone ☐ Email

Residential Address: (physical address is **required** to participate in the ACP)

Residential Street Address

Apartment/Suite #

City/Town

CT

State

ZIP Code

Mailing Address: (required if different than residential address)

Mailing Street Address

Apartment/Suite #

City/Town

CT

State

ZIP Code

Employer Address: (if applicable)

Name

Employer Street Address

Apartment/Suite #

City/Town

CT

State

ZIP Code

School Address: (if applicable)

Name

School Street Address

Apartment/Suite #

City/Town

CT

State

ZIP Code

Safe at Home: Address Confidentiality Program (ACP) Application

Address Confidentiality Program (ACP) Application Checklist

Required: Place a check next to each statement after you have reviewed it with the application assistant.

- ☐ I understand the limitations of the ACP and my responsibilities as a participant in the ACP.
- ☐ The ACP will only forward first class mail. Magazines and packages will be returned to the sender.
- ☐ I understand that my participation in the ACP is for a period of four (4) years. At the end of the four year period I must renew my participation in the ACP by filing a renewal application, as directed by the Secretary of the State, in order to continue my participation in the program.
- ☐ I understand that my participation in the ACP may be canceled if: (1) I change my name or confidential address and fail to notify the Secretary of the State in writing not later than thirty days after the change; (2) mail forwarded to me is returned to the Secretary of the State as non-deliverable; (3) my certification expires and I have not applied for renewal; or (4) my application for program participation or renewal contains false information.
- ☐ I understand that the ACP may not release my actual address to a third party unless: (1) it is requested by a law enforcement agency or by the State Elections Enforcement Commission; (2) if directed by court order; or (3) if my participation in the program has been canceled.
- ☐ I understand that my participation in the ACP is not confidential. If asked, the Secretary of the State may confirm only that I am participating in the program but may not release my confidential address.
- ☐ I understand and have discussed the impacts of sharing personal information with government agencies and private businesses. I understand that if I provide my real address to a government agency or private company my information may not be protected.
- ☐ The ACP is a mail forwarding service. By participating in the ACP, my mail will go first to the ACP and then the ACP will forward it to me. Participating in the ACP means it may take longer for me to receive my mail, including bills.
- ☐ I understand that the ACP cannot forward mail to me if it is addressed to a name other than the name on the enclosed application (for example, a nickname or a former name). I understand that I share the ACP address with other program participants. I understand that any time I move I will provide my new address, in writing, to the ACP and will not file a change of address with the United States Postal Service.
- ☐ By participating in the ACP, I am designating the Secretary of the State as my agent for service of process. This means that the Secretary of the State will accept legal documents on my behalf. I understand that service is effective as of the date and hour received by the Secretary of the State and that participating in the ACP means it will take longer for me to receive such process.
- ☐ It is my responsibility to let public agencies (state and municipal) know that I am an ACP participant and that I want to use the ACP substitute address. I understand that I must produce the ACP certification card whenever I am requesting ACP privileges.
- ☐ I understand that private companies (such as telephone and power companies, insurance agents, credit reporting agencies, department stores, title companies, etc.) don't have to accept my ACP substitute address. It is my responsibility to explore other options which may provide additional security when the ACP address is not accepted.

Please mail completed application to: ACP; P.O. Box 150469; Hartford, CT 06115-0469

Safe at Home: Address Confidentiality Program (ACP) Application

Co-Applicant Information: Additional Household Member(s)

Each co-applicant (aged 18 or older) or their guardian (if co-applicant is a minor) must initial the application.

Full Legal Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Relationship to Applicant	Initials
A.			
B.			
C.			
D.			

Note: If there are more than four co-applicants, please attach an additional page.

Primary Applicant Agreement

I am a victim of family violence, sexual assault, injury or risk of injury to a minor, or stalking or I am the parent, guardian or conservator of a victim of family violence, injury or risk of injury to a minor, sexual assault or stalking. I fear for: a) my safety; b) the safety of my children; or c) the safety of the person on whose behalf the application is made. I understand that I am making this statement under penalty of false statement, as provided in section 53a-157b of the Connecticut General Statutes. I hereby designate the Secretary of the State as the agent of the applicant or the person on whose behalf the application is made for service of process and for receipt of first class mail.

Applicant Signature

Date

Applicant Printed Name

Application Assistant Information Only

I assisted the applicant with the preparation of this application as required by C.G.S. § 54-240b.

Application Assistant Signature

Date

Application Assistant Printed Name

Agency

Email Address

Phone Number

Please mail completed application to: ACP; P.O. Box 150469; Hartford, CT 06115-0469