

ADDRESS CONFIDENTIALITY PROGRAM APPLICATION

Section 40-15-117 MCA

Please mail completed application to:

ACP
PO Box 201410
Helena, MT 59620-1410

<i>For ACP Use only</i>	
ACP # _____	Filed: _____

Type of application: <input type="checkbox"/> New <input type="checkbox"/> Reinstatement <input type="checkbox"/> Renewal <input type="checkbox"/> New Name <input type="checkbox"/> _____		
APPLICANT'S LEGAL NAME (First, Middle, Last)		DATE OF BIRTH (mm/dd/yyyy)
Mr. _____ Ms. _____		_____
Has applicant ever participated in a confidential address program in Montana or in another state? YES NO If yes, in what state? _____		
CO-APPLICANT NAMES (First, MI, Last) – Use additional paper if needed	DATE OF BIRTH (mm/dd/yyyy)	Relationship to applicant
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____

RESIDENTIAL ADDRESS (*Participant's actual residential address/physical location is required to participate in ACP*)

Street Address: _____ Apt/Suite#: _____

City: _____ MT ZIP: _____ County: _____

DAY TELEPHONE ()	EVENING TELEPHONE ()	MESSAGE/OTHER TELEPHONE ()
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BUSINESS NAME AND ADDRESS (*Fill out only if applicant owns a business*)

Business Name: _____ Address: _____

City: _____ MT ZIP: _____

I am (or the applicant for whom I am the parent/guardian is) a victim of:

sexual assault or **domestic violence** or **stalking.**

I am a resident of the State of Montana and have recently relocated to a place unknown to the abuser. I have determined that the Address Confidentiality Program (ACP) should be part of my safety plan. I understand that knowingly providing the ACP with false or incorrect information is punishable under 45-7-202, MCA or other applicable statutes and may jeopardize my participation in the program. To my knowledge, the information contained on this form is true and accurate.

I hereby designate the Montana Attorney General as my agent for service of process pursuant to 40-15-117, MCA. I understand that moving from the above residential address or changing my mailing address without first notifying the ACP may result in the cancellation of my participation in the ACP.

 Signature of Applicant or Parent/Guardian Date _____

State of _____)
 County of _____)

On this _____ day of _____, in the year 2____, before me _____, a notary public, personally appeared _____, proved on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged (he/she/they) executed the same. Witness my hand and official seal.

(Seal)

 NOTARY PUBLIC
 My Commission Expires: _____