



**MICHAEL G. ADAMS
SECRETARY OF STATE**

ADDRESS CONFIDENTIALITY PROGRAM PARTICIPANT NAME OR ADDRESS CHANGE

- Instructions:
1. Print in black or blue ink or type.
 2. Sign and date where indicated at the bottom of form.
 3. Return the completed application by email, fax, mail, or in person to the address listed at the bottom of the second page.

TYPE OF CHANGE	
<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Other (Specify) _____	Effective Date of Change

FILER'S INFORMATION , if being completed by someone other than program participant	
Name of Filer (first, middle, last)	Filer's Relationship to Program Participant
Filer's Address (number and street, city, state and ZIP code)	Filer's telephone number () - <input type="checkbox"/> Home <input type="checkbox"/> Cellular <input type="checkbox"/> Work <input type="checkbox"/> Other

PROGRAM PARTICIPANT INFORMATION	
This form is being completed by: <input type="checkbox"/> Applicant <input type="checkbox"/> Parent or guardian on behalf of minor applicant <input type="checkbox"/> Guardian of applicant declared incompetent <input type="checkbox"/> Designee of an applicant, parent or guardian of a minor, or guardian of a person declared incompetent who cannot apply for him or herself	
Name of Program Participant (first, middle, last) As Certified: New (if changed):	Participant Number
Program Participant's Address (number and street, city, state, and ZIP code) As Certified: New (if changed):	
Program Participant's Mailing Address for use by Secretary of State, if different (number and street, city, state, and ZIP code) As Certified: New (if changed):	
Program Participant's phone number for use by Secretary of State As Certified: - - <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other New (if changed): - - <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other	Alternate phone number for use by Secretary of State As Certified: - - <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other New (if changed): - - <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other

SIGNATURE OF PROGRAM PARTICIPANT OR FILER		
_____	_____	_____
Printed Name of Program Participant or Filer	Signature of Program Participant or Filer	Date

Please return completed application to:
Address Confidentiality Program
 c/o Secretary of State's Office
ATTN: Skyler M. Luttrell
 700 Capital Ave / Suite 152
 Frankfort, KY 40601

Contact Information:
SOS.KY.GOV (Website)
(844) 292-KACP (5227) (Toll free)
(502) 564-5687 (Fax)
KACP@ky.gov

For ACP Use only:
ACP # _____
Received: _____ **By:** _____