



**MICHAEL G. ADAMS  
SECRETARY OF STATE**

**APPLICATION FOR CERTIFICATION TO PARTICIPATE IN ADDRESS CONFIDENTIALITY PROGRAM**

- Instructions:
1. Print in black or blue ink or type.
  2. This is a **two-page** form. Complete both pages, sign and date where indicated on second page of form.
  3. Return the completed application by email, fax, mail, or in person to the address listed at the bottom of the back page.

<b>TYPE OF APPLICATION</b>				
<input type="checkbox"/> New Application	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Renewal	<input type="checkbox"/> Other (Specify) _____

<b>FILER'S INFORMATION</b> , if being completed by someone other than Applicant	
Name of Filer (first, middle, last)	Filer's Relationship to Applicant
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

<b>APPLICANT INFORMATION</b> (KRS 14.304)			
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 Applicant (first, middle, last)	Date of Birth (month/day/year)	Social Security Number -   -	Gender Female <input type="checkbox"/> or Male <input type="checkbox"/>
Applicant's Address (number and street, city, state, and ZIP code)			
Applicant's Mailing Address for use by Secretary of State, if different (number and street, city, state, and ZIP code)			
Applicant's telephone number for use by Secretary of State (    )    - <input type="checkbox"/> Home <input type="checkbox"/> Cellular <input type="checkbox"/> Work <input type="checkbox"/> Other		Alternate telephone number for use by Secretary of State (    )    - <input type="checkbox"/> Home <input type="checkbox"/> Cellular <input type="checkbox"/> Work <input type="checkbox"/> Other	

<b>STATEMENT OF QUALIFICATION</b> (KRS 14.304)
<p>I am, or the applicant, minor, or incompetent person on whose behalf this application is made is, a victim of an offense specified in KRS 14.300(7) in an ongoing criminal case or in a criminal case that resulted in a conviction by a judge or jury or by a defendant's guilty plea.</p> <p><b>OR</b></p> <p>I have, or the applicant, minor, or incompetent person on whose behalf this application is made has, been granted an emergency protective order or a domestic violence order under KRS Chapter 403 by a court of competent jurisdiction within the Commonwealth of Kentucky, and the order is in effect at the time this application is being made.</p> <p><b>AND</b></p> <p>Disclosure of the applicant's address would endanger the safety of the applicant, the applicant's children, or the applicant, minor, or incompetent person on whose behalf this application is made.</p>

**CONDITIONS**

By signing this application, I acknowledge that:

\_\_\_\_\_ Participation in the Address Confidentiality Program (ACP) cannot guarantee applicant's safety, and the ACP does not provide direct counseling services.

\_\_\_\_\_ If certified, the program participant or a filer shall notify the Office of the Secretary of State of a change of the program participant's address within seven (7) days of the change of address.

\_\_\_\_\_ The Secretary of State may cancel certification for failure to notify the Office of the Secretary of State of a name change or a change of address within fourteen (14) days of the date of the change.

\_\_\_\_\_ The Secretary of State shall cancel certification if the application contains false information.

\_\_\_\_\_ The Secretary of State shall cancel certification if the program participant is required to register as a sex offender.

\_\_\_\_\_ Certification as a program participant is effective for two (2) years following the date of filing unless the certification is withdrawn or cancelled before that date.

\_\_\_\_\_ Falsely attesting that disclosure of applicant's address would endanger the safety of applicant or the safety of the applicant's children, or the minor or incompetent person on whose behalf the application is made, or knowingly providing false or incorrect information upon making an application, could result in a finding of guilt of perjury in the second degree under KRS 523.030.

\_\_\_\_\_ If applicant is certified as a program participant and wants to withdraw from the program, the program participant or a filer must submit to the Secretary of State a Withdrawal from Participation in Address Confidentiality Program form.

\_\_\_\_\_ The Secretary of State will make applicant's records available for copying or inspection only if directed by a court order signed by a judge or justice of a court of competent jurisdiction within the Commonwealth of Kentucky OR upon written request by the chief law enforcement officer of a city or county, or the commander of a Department of Kentucky State Police post or branch, if related to an ongoing official investigation.

**SIGNATURE OF APPLICANT OR FILER (KRS 14.304)**

I, the applicant, parent or guardian on behalf of a minor applicant, guardian acting on behalf of a person who is declared incompetent, or designee of an applicant or a parent or guardian of a minor or a guardian of a person declared incompetent who cannot apply for him or herself, swear or affirm, under the penalty of perjury in the second degree, that the information contained in the "Applicant Information" and "Statement of Qualification" portions of this application is true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Printed Name of Applicant or Filer

\_\_\_\_\_  
Signature of Applicant or Filer

\_\_\_\_\_  
Date

**SIGNATURE OF AGENCY REPRESENTATIVE, if applicable (KRS 14.304; 14.310)**

I am a representative of a referring agency designated pursuant to KRS 14.310 and assisted applicant or filer in preparing this application.

\_\_\_\_\_  
Printed Name of Representative & Agency

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date

**NOTARIZATION**

State of Kentucky  
County of \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Commission Expires: \_\_\_\_\_

Please return completed application to:  
**Address Confidentiality Program**  
c/o Secretary of State's Office  
ATTN: Program Coordinator  
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: \_\_\_\_\_