Application Instructions
Address Confidentiality Program

State of Rhode Island
RI Department of State

To apply to be a Program participant in the Address Confidentiality Program (ACP/Program), complete this application. All applicants should review the instructions below to ensure they understand how to properly complete the application.

Section 1 - Primary Participant Information

Primary Participant Name

The Program participant should include their full legal name and date of birth. Please also list any other names by which the Program participant is currently or has formerly been known.

The applicant may be an adult who: (i) is a victim of "domestic violence" or "abuse" as defined in RI Gen. Laws § 42-164-2; (ii) fears for their safety or the safety of their children; and (iii) has left or will be leaving 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 so long as the applicant has legal authority to act on the minor's or incapacitated person's behalf. The applicant must affirm in Section 3 whether they are applying on their own behalf or on behalf of a minor or incapacitated person and sign the affirmation.

Other Participants

This section may include other members of the same household as the primary participant who need to participate in the ACP to keep the primary participant safe. Other adults in the primary participant's household must also complete the affidavit contained within Section 4.

If the applicant is including a minor or incapacitated person in their application, they should list them here. 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), they must complete a new application and sign Section 4 to continue participating in the ACP. If this new adult household member does not submit a new application, their name may be removed from the Program.

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

Primary Participant's Address

This is the address where the primary participant lives. Applicants must complete this section. The address cannot be a Post Office (PO) Box. Participation in the ACP is limited to Rhode Island residents. The primary participant must provide a phone number so that the ACP can reach them. The ACP recommends that the participant indicate the best time of the day to receive calls.

Email Address

Please include the Program participant's email address as another method of contact.

Primary Participant's Mailing Address

This is the address where the primary participant would like their mail delivered. This may be left blank if it is the same address as the actual address. The ACP can send mail to a PO Box or to an address other than the actual address.

If the address changes, the Program participant should contact the ACP for instructions on how to change their address. Do not file a change of address with the Post Office.

ACP Identification Number

This is the unique identification number issued to each primary ACP participant. If the Program participant is new to the Program, they will receive a letter from the Department of State that contains their ACP number in the mail. If an application involves a participant that already has been issued an identification number, the participant should include their existing ACP number on the application.

Agency that employs a person who committed an act of domestic violence or abuse

This is for the applicant to indicate if there is a state, federal, or local agency that employs an individual who committed an act of domestic violence or abuse against the participant.

Section 2 - Program Information

The applicant should thoroughly read and understand each item in this section. An application assistance provider can explain the meaning of each of the statements in this section.

Section 3 - Program Participant Affidavit

The applicant should indicate whether they are completing the application on their own behalf or completing the application as the legal guardian of the Program participant indicated on the application. An applicant must have the legal authority to act on behalf of any minor, ward, and/or incapacitated person included on the application.

The Program participant or legal guardian must sign their 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 they understand how the ACP works and the requirements of being enrolled in the Program.

Section 4 - Other Adult Member(s) of the Household Affidavit

Adult members of the primary participant's household are also eligible to enroll in the Program. This form may be copied and filled out by each participating adult member.

Each adult member must sign their 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 ACP to the applicant and helps complete the form(s), the application should include the name of the organization.

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

Completed applications should be sent to the address indicated below:

Department of State
Attention: ACP
PO Box 6888
Providence, RI 02940

Application
Address Confidentiality Program

State of Rhode Island
RI Department of State

→ Please read all instructions carefully before completing this application.

→ Please type or print responses in blue or black ink.

Section 1 - Primary Participant Information

First Name	MI	Last Name	DOB - (MM/DD/YYYY)

Any other names by which you are currently or have formerly been known:

I am a victim of Domestic Violence and/or Abuse, as defined in RI Gen. Laws § 42-164-2

☐ YES ☐ NO

Other Participants - Must be a minor/incapacitated adult living in the same household*

First Name	MI	Last Name	DOB - (MM/DD/YYYY)
First Name	MI	Last Name	DOB - (MM/DD/YYYY)

*If there are additional participants, please use an additional sheet to list their information.

Primary Participant's Address - Address where the applicant lives

Address	City/Town	State	Zip Code
		Rhode Island	
Phone Number	Best Time of Day to Call:	Email Address	

Primary Participant's Mailing Address - Address where ACP will send the applicant's mail if different than above

Address	City/Town	State	Zip Code
		Rhode Island	

Have you ever participated in Rhode Island's Address Confidentiality Program?

☐ YES ☐ NO **if YES, provide ID#**

Does any state, federal, or local agency employ a person who committed an act of abuse or domestic violence against you or your child/ward?

☐ YES ☐ NO **If YES, what agency**

Section 2 - Program Information

I understand that the ACP is a mail forwarding service only and that my mail will first come to the Program's PO Box in Providence 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 the ACP will only forward first-class mail and legal documents to me and WILL NOT forward magazines, catalogs, packages, or junk mail unless it is clearly identifiable as pharmaceuticals, or it 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 identification number. 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 with the ACP. I also understand that if I complete an application 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 telephone, utility, etc.) are not obligated to use the ACP substitute address and may require an actual residential address. I understand that I should contact private companies to inquire about their willingness to allow the use of the designated PO Box.

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 or if requested by a law enforcement agency for legitimate law enforcement purposes.

Section 3 - Program Participant Affidavit

I affirm that I, as the Program participant, am a victim of "domestic violence" and/or "abuse" as defined in RI Gen. Laws §42-164-2. I fear for my safety and/or the safety of my children or ward. I reside or will reside at a location in Rhode Island that is not known by the person who committed domestic violence or abuse, or who threatens me or my child or ward with domestic violence or abuse. I will not disclose my actual address to the person who committed domestic violence or abuse or threatens me or my child or ward with domestic violence or abuse. 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 that incapacitated person who is a victim of "domestic violence" and/or "abuse" as defined in RI Gen. Laws §42-164-2. I fear for the safety of my ward. My ward will reside at a location in Rhode Island that is not known by the person who committed domestic violence or abuse or who threatens my ward with domestic violence or abuse. I will not disclose my actual address to the person who committed domestic violence or abuse or threatens my ward with domestic violence or abuse. I have legal authority to act on behalf of the incapacitated person included on this application.

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 (including prescriptions/medications). 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 Department of State as my agent for service of process and receipt of mail. As required by RI Gen. Laws § 42-164-3(b)(4)(i)-(ii), I hereby acknowledge that acceptance into the Address Confidentiality Program does not relieve me of any legal responsibility, including, without limitation, court summonses, subpoenas, divorce or child custody orders and arrest warrants. I also acknowledge that failure to promptly notify the Department of changes to my contact information, including address, email address and telephone number, may cause a delay on my receipt of legal documents, including notices of upcoming court hearings for divorce, child custody, or criminal matters, which may result in negative legal ramifications for me, including, without limitation, a default for failure to respond.

Signature of Applicant	Print Name of Applicant	Date

Section 4 - Other Adult Member(s) of the Household Affidavit (if applicable)

This section should be completed by any adult member of the same household as the primary participant. If there is more than one adult member of the same household, please 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.

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 (including prescriptions/medications) through this Program. I understand that the ACP does not forward magazines, packages, or junk mail. I hereby designate the Department of State as my agent for service of process and receipt of mail.

Signature of Applicant	Print Name of Applicant	Date

Section 5 - Application Assistance Provider (if applicable)

Agency Name: _____

Agency Phone Number: _____

Agency Contact Name: _____

Agency Signature: _____

Send all ACP materials to:
Department of State
Attention: ACP
PO Box 6888
Providence, RI 02940

Applicants can contact the Department of State by email (acp@sos.ri.gov), phone (401-222-2357), or in-person (148 W. River St., Providence) for help filling out the application.