

Confirmation of Participant Information



NYS Department of State
Address Confidentiality Program
P.O. Box 1110
Albany, NY 12201-1110
Phone: (518) 474-7306
Toll Free: (855) 350-4595
Fax: (518) 474-0709
Email: ACP@dos.ny.gov
Web: www.dos.ny.gov/acp

Address Confidentiality Program (ACP)

Please PRINT or TYPE responses in ink.

I, _____, am seeking confirmation of the following information:

Participant Name: _____ ACP Identification # _____
(if known)

Information:

Reason for Requesting Confirmation:

PLEASE NOTE - The ACP Program will provide notification to the program participant of a request to confirm an actual address prior to providing confirmation of the participant information.

Print Name

Signature of person seeking confirmation

Title

Date

Agency

Agency Address

Agency Phone Number

Please return the completed Confirmation of Participant Information to:	NYS Department of State Address Confidentiality Program P.O. Box 1110, Albany, NY 12201-1110
OR return to ACP via Fax at: (518) 474-0709	

ACP Section

The ACP participant was provided notification of this request on _____

The requested information was provided to _____ on _____

How was the information provided? _____