

AFFIRMATION of APPLICANT

I (or the co-applicant for whom I am the parent/guardian of) am/is a victim of domestic abuse, stalking or sexual assault. I fear for my safety and/or the safety of the co-applicant. I am a resident of Indiana and have relocated to a place unknown to the abuser. My application assistant and I have determined that the Address Confidentiality Program (ACP) should be a part of my safety plan. I understand that knowingly providing false or incorrect information is punishable under IC 35-44-2-1 (carrier a penalty of a Class D Felony for perjury) or other applicable statutes and may also cancel my participation in the program.

I hereby designate the Attorney General as my agent for service of process and receipt of mail pursuant to IC 26.5-2. I understand that moving from the residential address stated above, or changing my address without first notifying the ACP, may result in the cancellation of my participation in the ACP. I can sign for and accept legal documents at my:

Please Check One Mailing Address Residence Address Work Address

Signature of Applicant (*first, middle, last*)

Date (*month, day, year*)

I helped this applicant develop a plan that we believe should include the Address Confidentiality Program (ACP). I will forward this paper work to the ACP.

Name of applicant assistant / domestic violence advocate

Telephone number

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Name of Organization

County of Organization

Please take a moment to tell us how you heard about the Victim's Assistance Program

Center for Women/Shelter

County Clerk's Office

County Prosecutor's Office

Friends or Family

Healthcare Facility

Media (*Newspaper, radio, TV*)

Other