Address Confidentiality Program
Health Care Application

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Secretary of the Commonwealth

Instructions

An applicant must complete an application in order to determine eligibility to become a participant in the Address Confidentiality Program (ACP). All applicants should review the instructions below to ensure they understand how to properly complete the application form. Please include a photo copy of the ID of any adult applying for the program and birth certificate for any minors. Completed applications should be mailed to "Address Confidentiality Program, PO BOX 9120, Chelsea, MA 02150."

Section 1 – Participant Information

Qualifications

The applicant must be an individual engaged in the provision, facilitation or promotion of a legally-protected health care activity. Legally protected health care activities include:

- "Gender-affirming health care services," all supplies, care and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventative, rehabilitative or supportive nature relating to the treatment of gender dysphoria; and
- "Reproductive health care services," all supplies, care and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventative, rehabilitative or supportive nature relating to pregnancy, contraception, assisted reproduction, miscarriage management or the termination of a pregnancy.

Driver's License/State Identification Number

An applicant is not required to have a driver's license or state identification card in order to apply. However, if the applicant does already have a driver's license or state identification card, it is helpful for ACP to have this information to assist the applicant in obtaining a driver's license or state identification with an alternative address from the Massachusetts Registry of Motor Vehicles.

Applicant's Residential Address

This is the address where the applicant lives. Applicants must complete this section. Participation in the ACP is limited to Massachusetts residents. The applicant must provide a phone number so that the ACP can reach them.

Applicant's Mailing Address

This is the address where the applicant would like all their mail delivered. This may be left blank if it is the same as the residential address. The ACP can send mail to a post office box or to an address other than the residential address. If this address changes, please contact the ACP for instructions on updating an address. Do not file a change of address with the U.S. Post Office. Please note, ACP is unable to forward packages other than medical supplies.

Minor or Incapacitated Persons Section

This is the section to include the residential, mailing, business or school address(es) of any minors or incapacitated persons applying to the ACP.

Section 2 – Applicant Affidavit

The applicant 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, applicants are affirming that they understand how the ACP works and the requirements of being enrolled in the program.

Section 1: Participant Information

Applicant Name: _____

Preferred title, if any.

Select one: ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. ☐ Mx. ☐ Dr. ☐ Self-describe: _____

Gender Identification: ☐ Male ☐ Female ☐ Non-binary

☐ Self-describe: _____ ☐ Prefer not to say

Driver's License/State Identification Number: _____ Date of Birth: _____

Contact Telephone Number(s):

Home: _____ Business: _____ Mobile: _____

Email address: _____

How did you hear about the ACP?: _____

Residential Address:

Street address (include Apt. #): _____

City: _____ State: _____ Zip code: _____ County: _____

Mailing Address (if different than physical address):

Street address (include Apt. #): _____

City: _____ State: _____ Zip code: _____ County: _____

Business Address (required):

Name of employer/company/medical practice: _____

Street address (include unit/suite #) _____

City: _____ State: _____ Zip code: _____ County: _____

School Address (if applicable):

Name of school: _____

Street address: _____

City: _____ State: _____ Zip code: _____ County: _____

Name of Supervisor (if applicable):

Supervisor's Contact Information: _____

Telephone number: _____ Email address: _____

Job Title: _____

COMPLETE ONE SHEET FOR EACH MINOR or INCAPACITATED PERSON

Provide the following information for each minor or incapacitated person seeking to participate in the program:

Name: _____

Relationship to applicant: _____ Date of birth: _____

Residential Address:

Street Address (include Apt. #): _____

City: _____ State: _____ Zip code: _____ County: _____

Mailing Address (if different than residential address):

Mailing Address: _____

City: _____ State: _____ Zip code: _____ County: _____

Business Address (if applicable):

Name of employer/company: _____

Street address (include unit/suite #): _____

City: _____ State: _____ Zip code: _____ County: _____

School Address (if applicable):

Name of school: _____

Street address: _____

City: _____ State: _____ Zip code: _____ County: _____

Section 2: Applicant Affidavit

I affirm under pains and penalties of perjury that each person seeking admission to the Program:

1. is a resident of Massachusetts;
2. is engaged in the provision, facilitation, or promotion of a legally-protected health care activity, as defined by G. L. c. 9A, § 1;
3. agrees to use the designated substitute mailing address and, if applicable, the designated street address on motor vehicle operator licenses, registration and excise tax;
4. agrees to promptly disclose in writing to the Program any civil, criminal or administrative proceeding in which he/she is a witness or party and any court order including, but not limited to, divorce proceedings, child support, child custody and visitation orders;
5. understands the regulations, policies and limitations of the program;
6. designates the Secretary of the Commonwealth as the person's agent for service of process and receipt of mail, including service of process by mail received at the Registry of Motor Vehicles;
7. acknowledges that participation in the Address Confidentiality Program does not protect from prior disclosures of the participant's address;
8. agrees to immediately inform the Address Confidentiality Program of a participant name change to limit disruption to mail forwarding services;
9. understands that program certification is valid for four years from date the application is certified by the Program Manager unless sooner withdrawn or cancelled pursuant to 950 CMR 130.09. Program certification will be cancelled if the participant:

    (a.) no longer resides in Massachusetts;

    (b.) discloses the participant's residential or business address to any state or local agency;

    (c.) fails to agree to or to use the designated substitute mailing address or, if applicable, the designated street address on motor vehicle operator licenses, registration or excise tax;

    (d.) fails to agree to or abide by any written Program rule, policy or procedure previously communicated to the participant;

    (e.) fails to notify the Program Manager in writing of a change in contact information as provided in 950 CMR 130.05(3);

    (f.) fails to disclose in writing to the Program Manager any civil, criminal or administrative proceeding as provided in 950 CMR 130.05(5);

    (g.) provides false or misleading information in the application or to any state or local agency in connection with the Program; or

    (h.) uses or attempts to use the Program to evade law enforcement or to avoid establishing or following child custody or visitation orders.

Signature of applicant (or parent or guardian): _____ Date: _____