

# NEVADA'S CONFIDENTIAL ADDRESS PROGRAM



## Change of Information Form

Current CAP Authorization Number \_\_\_\_\_

Participant's Name listed with CAP: (First, Middle, Last) \_\_\_\_\_

Alias (current or in the future) \_\_\_\_\_

### **PLEASE BE ADVISED**

*Participation may be cancelled if you fail to notify the Confidential Address Program within 48 hours after the change of address. This form is for current Confidential Address Program participants. Participation in the Confidential Address Program is subject to NRS 217.462.*

**NAME CHANGE FOR ALL PARTICIPANTS**– *Please provide a copy of the judgment ordering the change.*

**NEW NAME(S)** \_\_\_\_\_

### UPDATES FOR PARTICIPANT CONTACT INFORMATION

MAILING ADDRESS: (Address where CAP will send the applicant's mail)			
Mailing address (including Apt/Suite #)	City	State	Zip
RESIDENCE ADDRESS (ACTUAL physical street address)			
Physical address (including Apt/Suite #)	City	State	Zip
EMPLOYER NAME and ADDRESS			
Employer name: _____			
Employer address (including Apt/Suite #)	City	State	Zip
Employer phone number: _____			
PHONE NUMBERS and EMAIL			
Daytime Phone: _____		Evening Phone: _____	
Cell Phone: _____		Email: _____	
Message Phone: _____		Contact Name for Message Phone: _____	

**UPDATES FOR CO-APPLICANTS**

(First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Relationship to applicant	Is this a new dependent to the program?	Does this applicant want to register to vote?	Is co-applicant attending school?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I fear for my safety and/or the safety of the applicant on whose behalf this application is made. I understand that knowingly providing false or incorrect information on this form is a misdemeanor and may cause my participation in this program to be cancelled. *I hereby designate the Department of Health and Human Services, Division of Child and Family Services, as my, or the minor or incompetent person's agent for service of process and receipt of mail.*

Print Name (Applicant)	Signature of Applicant or Parent/Guardian	Date

Please mail, email or fax the completed form to:

**CAP**  
**Post Office Box 2743**  
**Carson City, NV 89702-2743**  
[NVCAP@dcs.nv.gov](mailto:NVCAP@dcs.nv.gov)  
**Fax: 775-687-9017**

For CAP Use Only		
Filed	CAP#	Received

