

ALLIANCE FOR CONSUMER PROTECTION

Phone 724-770-2078

469 CONSTITUTION BOULEVARD, ROUTE 51

ACP Use:

Fax 724-770-2079

NEW BRIGHTON, PA 15066

Date Recorded _____

www.acp-beaver.org

File # _____

Your Name _____	Name of Company or Individual Complained Against _____
Address _____	Address _____
City _____ Zip _____	City _____ State _____ Zip _____
Phone _____ (Home)	Phone _____ Fax _____ (Work)
email _____	email _____ web site _____
Name of Company Representative(s) you have spoken to and dates: _____	

Please provide your current status. This does not affect the way your case is handled.
This information is required for state and federal grant reporting.

<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Minority	Number of people in your home? _____	<u>Family Size</u>	<u>Circle Monthly Income</u>
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Full-time Employee		1	\$1,063.58
<input type="checkbox"/> Social Security	<input type="checkbox"/> Part-time Employee		2	\$1,426.08
<input type="checkbox"/> Youth (16 -- 24)	<input type="checkbox"/> Single Parent		3	\$1,788.58
<input type="checkbox"/> Some High School	<input type="checkbox"/> None of these		4	\$2,151.08
<input type="checkbox"/> Social Security Disability			5	\$2,513.58
			6	\$2,876.08
			7	\$3,238.58
		8	\$3,601.08	

For family units with more than eight (8) members, add \$362.50/month for each additional member.

Please provide the details of your case including: **Important Dates, Price, Warranties, Promises made to you at time of purchase, Guarantees, Attempts made to resolve your dispute, Type of settlement you desire.** *PLEASE* enclose photo copies of all relevant documents (Sales slip/receipt, Contract, Canceled checks - both front and back), Warranties/Guarantees, as well as Income Verification, and return to the above address.

Summarize the sequence of events below:

Attach additional summary sheets if needed.

Please read the statements on the back of this form and sign, indicating the information provided is correct and authorizing this office to discuss financial matters on your behalf.

Your Signature _____

Equal Opportunity Agency

For office use only:

Complaint Category: _____

How Resolved: _____

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I/We certify that, to the best of our knowledge and belief, the information provided in this application is true and correct. I/We authorize the ALLIANCE FOR CONSUMER PROTECTION to verify the above information, and understand that all information provided is confidential.

Your Signature _____

Date _____

I/We hereby authorize the ALLIANCE FOR CONSUMER PROTECTION office to discuss financial matters, credit cards, medical bills, landlord tenant and/or other mediation required relating to my/our complaint.

Your Signature _____

Date _____

NOTE: If this complaint deals with financial matters or medical bill, please provide the last four digits of your Social Security Number - ____ _

I/We are informed that the OFFICERS, DIRECTORS, STAFF AND CONSUMER CONSULTANTS of the ALLIANCE FOR CONSUMER PROTECTION are not individually, severally or jointly liable for errors or omissions in the advice or actions taken in attempting to resolve my/our complaint. The Alliance for Consumer Protection cannot guarantee the outcome.

Your Signature _____

Date _____