Alliance for Consumer Protection, Beaver County

3607 Brodhead Road • Monaca, PA 15061
724-888-5931 • www.acp-beaver.org

DISPUTE ASSISTANCE REQUEST FORM

Your Contact Information

Name: _____

Address: _____

_____

Telephone: _____ Cell: _____

Email: _____

Your Dispute is with:

Business Name: _____

Address: _____

_____

Telephone: _____ FAX: _____

Web Site: _____

Representatives You Have Contacted: _____

Describe the Situation:

Please provide the details of your case including: Important Dates, Price, Warranties, Promises made to you at the time of purchase, and Attempts made to resolve your dispute. PLEASE enclose copies of all relevant documents (sales slips, contract, canceled checks - both front & back and guarantees/warranties). You may use the other side of this page if necessary. Summarize the sequence of events.

Your Desired Outcome?

_____

_____

Your Authorization for ACP to Investigate your Case

I/We certify that, to the best of our knowledge and belief, the information provided on this form and any subsequent conversations are 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 my 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 any 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 but will make our best effort to assist you in resolving this matter to your satisfaction.

Your Signature _____ Date_____

Please indicate your current status IF APPLICABLE . We are required to collect this information to continue receiving our state and federal support grants. It does not affect the way your case is handled.

___Public Assistance
___Unemployed
___Retired
___Disabled
___SSI / SSD
___Youth (16-24)
___High School Dropout

___Minority
___Full-time Employment
___Part-time Employment
___Single Parent
___Veteran
___None of These

Family Size_____

Are you low income based on this income table? _____

Family Size	Monthly Income
1	$ 969.03
2	$ 1,301.08
3	$ 1,632.33
4	$ 1,963.58
5	$ 2,294.83
6	$ 2,626.08
7	$ 2,957.33
8	$ 3,225.00