



**STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION  
ASSISTED LIVING PROGRAM**

408 Leon Sullivan Way  
Charleston, West Virginia 25301-1713  
Telephone: (304) 558-0050 Fax: (304) 558-2515

**DECLARATION OF RELATIONSHIP**

**State of West Virginia**

**County of \_\_\_\_\_, To-Wit:**

I, \_\_\_\_\_ do hereby declare that  
(Name of Provider/First, Middle & Last Name of Resident & Maiden Name, If applicable)

\_\_\_\_\_ who was born on \_\_\_\_\_ at  
(First, Middle & Last Name of Resident \* Maiden Name, if applicable)

\_\_\_\_\_ is related to me in the following manner:  
(Birth Place – City & State)

\_\_\_\_\_  
(Relationship to you; explain)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
(Printed Signature)

Subscribed and sworn to me before this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_

\_\_\_\_\_  
Notary Public

(SEAL)

My commission expires: \_\_\_\_\_

**NOTE: You must provide documentation showing relationship and lines of relationship  
(birth certificate, marriage license, etc.)**