



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

**IDENTITY DECLARATION**

Name of Identified Person: \_\_\_\_\_  
Last First Middle

Sex:  Male  Female Person's Date of Birth: \_\_\_\_\_

Person's Place of Birth: \_\_\_\_\_  
City County State

Person's Current Address: \_\_\_\_\_  
\_\_\_\_\_

Declarant's Full Name: \_\_\_\_\_  
Last First Middle

Declarant's Relationship to Person: \_\_\_\_\_

Check one:  Parent  Guardian

I certify that all the information on this declaration is true, correct and complete. I understand that knowingly making a false or fraudulent statement or representation to the government may constitute a violation of federal or state law, and may result in imposition of a fine and/or imprisonment.

Declarant's Signature: \_\_\_\_\_

Declarant's Name (Printed): \_\_\_\_\_

Date Declarant Signed: \_\_\_\_\_