AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ADULT PROTECTIVE SERVICES (APS)

Declaration to Adult Protective Services

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH

I, _____, declare:
PRINT NAME HERE

Attach additional pages as needed. Number additional pages in order.

I declare under penalty of perjury under the laws of the State of Washington that the facts I have provided on this form (and any attachments) are true.

☐ I have attached _____ page(s)
NUMBER

DECLARANT'S SIGNATURE	DATE	SIGNED AT (CITY AND STATE)