

Adult Foster Care
Resident Rights Receipt

Person Name: _____

Program Name: _____

This packet contains information regarding your rights while receiving services and supports from this program, information on restriction of your rights, and information of where you can go if you have questions or need additional information related to your rights.

- I received the following information upon admission:
1. A copy of my rights under the law, Minnesota Statutes, section [245A.11, subd. 10](#).
 2. An explanation of what my rights are and that I am free to exercise my rights; and that this program must help me exercise my rights and help protect my rights.
 3. A written summary of the Vulnerable Adults Protection Act.

- If my rights are or will be restricted in any way to protect my health, safety, and well-being, the restriction has been explained to me and I understand the program must document and implement the restriction as required by law to make sure I get my rights back as soon as possible.

Are there any restrictions placed on my rights? Yes (if yes, see IAPP) No

- I understand that I may contact the agency below if I need help to exercise or protect my rights:

Washington County Community Services
Adult Foster Care Licensing
14949 62nd St. N.
Stillwater, MN 55082
651-430-6455 (ask for licensing in day person or adult foster care licensor)
ComSvsAFCLicensing@co.washington.mn.us

- I want _____ to help
(my authorized representative/legal representative/family member)
me exercise my rights. The program has this person's contact information in my record.

By signing this document I am agreeing that I have read and understand the boxes I checked above.

Person/Legal Representative's Signature_____
Date