LG Links Inc.

Enhanced Care Management - Member Consent Form

I agree to participate in the Enhanced Care Management (ECM) program and to share data within my care team.

I understand that:

- The purpose of ECM is to help me better manage my health.
- My participation in this program will give me a care team to help me better understand and manage my health.
- ECM participation will not affect my other medical benefits.
- ECM does not require me to change my doctor(s).
- ECM services end if I no longer meet ECM eligibility requirements, no longer receive ECM services, or if the care team says I no longer need ECM services.
- ECM is a voluntary program, and I can withdraw from the program at any time.

_____
Date of Member Opt-In

LG Links Inc.
ECM Provider

_____
Print Member Name

_____
Member CIN #

_____
Member Date of Birth **(MM/DD/YYYY)**

_____
Member Signature

_____
☐ Parent or Legal Guardian Name
(if applicable, mark checkbox)
☐Parent ☐Legal Guardian

_____
Parent or Legal Guardian Signature
(if applicable)
☐ Verbal consent was obtained

_____
Parent or Legal Guardian Relationship
(if applicable)

_____
ECM Care Team Member Name

_____
ECM Care Team Member Signature