

Date: \_\_\_\_\_  
Member Name: \_\_\_\_\_  
Identification Number: \_\_\_\_\_

Dear «firstname» «lastname»:

### **Welcome to Case Management!**

This letter serves as an introduction of case management services that have been identified on your behalf by Family Practice Medical Group of San Bernardino, Inc. (FPMG). It also confirms your agreement to participate in our Case Management Program. Case Management is a voluntary program designed to help you coordinate health care benefits for your medical conditions or chronic care needs with a goal to help improve your health. Case management services are provided at no additional cost to you. Licensed health care professionals trained in Case Management and familiar with your benefit plan provide these services. I have been assigned as your Case Manager. My role is to help you and your health care providers optimize your health care benefits. I will work with you and your physician as needed to develop a Case Management Plan that is designed to help meet your needs by using available benefits and resources.

I will stay in contact with you by telephone on a periodic basis. If you have any questions or needs regarding your Case Management Plan, please call me at the number below. You may receive written notifications of Case Management actions and recommendations, such as when a significant change occurs in your care management plan. To assist you with the coordination of health care services, there may be times when certain information needs to be shared with your treating physician or other health care provider.

Please take a moment to read over the attached Member Bill of Rights. Please sign and return the last page of this letter to the address noted on the form within 7 calendar days.

If you would like to give us permission to speak to your family or friends about your case management plan, please ask us for a HIPAA Authorization form.  
You may Opt Out of Case Management at any time by simply calling to make your request.

If you have any questions about the Case Management Program, how you were selected for Case Management services, or reasons for ending Case Management services, please contact me at the number or address listed below. If you have complaints or concerns regarding services provided under the Case Management Program, call the Case Management Department at 1-909-883-8966 weekdays between 08:30a.m. and 5:00p.m.

Sincerely,

FPMG Case Management  
Enclosures  
Member Bill of Rights; Agreement to Participate in the Case Management Program

Family Practice Medical Group of San Bernardino, Inc. Case Management Program

## **Member Bill of Rights**

### **As a member of FPMG, you have the right to:**

- Confidentiality and privacy of health information in accordance with state and federal law.
- Be understood and treated well, even if you have limited English skills, a different cultural background, or a disability.
- Receive information in a language or method you can understand.
- Take part in decisions about your health care treatment with your doctor.
- Designate or authorize another party to act on your behalf.
- Have your advance medical directives (living will and/or medical power of attorney) respected and honored by your health care provider(s).
- Express concerns and complaints about care and services you receive.
- File a complaint without fear of reprisal.

### **As a participant in the FPMG Case Management Program, you have the right to:**

- Have Case Management services provided with respect and dignity, and without discrimination.
- Provide input to the Case Management Plan developed by the Case Manager to address your identified health care needs.
- Receive a copy of your Case Management Plan upon request.
- Know and understand the reasoning for selecting cases for Case Management and for ending or closing Case Management services.
- Question how decisions are made regarding your eligibility for Case Management services.
- Receive notification when Case Management services are changed or terminated and the reason(s) why.
- Be informed of choices regarding Case Management services.
- To have others involved in your care to participate in the Case Management assessment.
- Refuse or disenroll from Case Management services, with an explanation provided to you on the implications of refusal in relation to your benefits and health conditions.

Agreement to Participate in the Case Management Program

**Please sign and return this page to:**

Family Practice Medical Group of San Bernardino, Inc.  
Attn. Case Management  
1369 East Highland Ave.  
San Bernardino, CA 92404  
or  
Fax this page to (909) 881-1480  
or  
Scan and e-mail to [jennifer.campbell@fpmgrp.org](mailto:jennifer.campbell@fpmgrp.org)

- I agree to participate in the Case Management Program offered by FPMG.
- I understand that it is a voluntary program provided at no additional cost to me.
- I have read this letter and understand the information in it.
- I have also read and understand the information listed in the "Member Bill of Rights" section of this letter.

**Member's Name (Please Print):** \_\_\_\_\_

**Member's ID Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Best Date/Time to Call:** \_\_\_\_\_

**Member's Signature:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorized Representative (Complete Only If Applicable)**

**Name of Authorized Representative (Please Print):** \_\_\_\_\_

**Relationship to Member:** \_\_\_\_\_

**Signature of Authorized Representative:**

\_\_\_\_\_ **Date:** \_\_\_\_\_