

MEMORANDUM OF UNDERSTANDING

This agreement is made by and between [COMMUNITY HEALTH CENTER (CHC)] and [DOMESTIC VIOLENCE (DV)/SEXUAL ASSAULT (SA)/HUMAN TRAFFICKING (HT) AGENCY/COMMUNITY-BASED ORGANIZATION (CBO)] to promote health and safety outcomes for patients/clients who have experienced domestic/sexual violence and/or human trafficking/exploitation. The purpose of this work is to strengthen collaboration between staff from both entities and promote bidirectional warm referrals for clients/patients and staff. [ADD IN ADDITIONAL VALUES OR ACTIONS i.e. to exchange information, education and training; coordinate services including health center enrollment and transportation; develop health care policies to support patients experiencing DV/SA/HT and reduce barriers to health care for clients within DV/SA/HT/CBO advocacy programs; provide mutual collaboration and trainings, partner on grants/funding, etc.].

[Use this space to provide a brief description of each partner agency].

The parties above and designated agents have signed this document and agree that:

- 1) Representatives of [DV/SA/HT/CBO Agency] and [community health center] will meet each other in-person or via video/phone at least once at the inception of this collaboration to understand the services currently provided by their respective programs and to discuss needs, goals, and next steps.
- 2) Representatives of [DV/SA/HT/CBO Agency] and [community health center] will continue to meet between [date] and [date] *[list frequency and meeting location/format and recurring schedule, as possible]*.
- 3) [Community health center] will hold the following roles and responsibilities: *[list the responsibilities and role of the health center—i.e. training DV/SA/HT/CBO advocates on health center services and health enrollment for new patients, and supplemental/refreshers trainings as needed; serving as a primary health care referral for clients referred by the DV/SA/HT/CBO program; drafting and reviewing IPV/HT policies and procedures; offering health education, enrollment support, or resources to clients in DV/SA/HT/CBO programs; etc.]*.
- 4) [DV/SA/HT/CBO Agency] will hold the following roles and responsibilities: *[list the responsibilities and role of the DV/SA/HT/CBO agency—i.e. training health center providers and staff on DV/HT dynamics and community supports and supplemental/refreshers trainings as needed; serving as a primary referral for health center patients or staff in need; drafting and reviewing policies; offering DV/SA/HT advocacy support onsite at health centers or virtually via telehealth etc.; tabling materials/resources at health fairs or other health events/virtual events; etc.]*.
- 5) [Community health center] will provide the following resources: *[list resources that the health center can bring to support the project's efforts—i.e. additional staff time; health enrollment specialists; vaccination clinics for children; office space for advocates co-located at the health center; funding; key contacts; condoms, Plan B or other reproductive health support; COVID-19 information, testing or vaccination; CHC brochures; etc.]*
- 6) [DV/SA/HT/CBO Agency] will provide the following resources: *[list resources that the organization can bring to support the project's efforts—i.e. additional staff time; 24/7 hotline; materials/program brochures; telehealth client support; key contacts; funds; etc.]*.
- 7) [DV/SA/HT/CBO Agency] and [community health center] staff will review and discuss evaluation tools offered on www.IPVHealthPartners.org to help measure the success and challenges of their collaboration and outcomes *[examples include a Quality Assessment/Quality Improvement tool used every six months to measure progress; a referral tracking tool; client/patient satisfaction surveys; and provider/staff training evaluations]*.

We, the undersigned, approve and agree to the terms and conditions as outlined in the Memorandum of Understanding. This agreement will be valid from [date] to [date], and may be renewed at the end of this period if both parties agree.

Name & Location of Community Health Center _____

Staff Name _____ Title _____

Signature _____

Date _____

Name and Location of DV/SA/HT/CBO Agency _____

Staff Name _____ Title _____

Signature _____

Date _____

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This tool was developed by [Health Partners on IPV + Exploitation](http://www.healthpartnersipve.org), a project of [Futures Without Violence](http://www.futureswithoutviolence.org). For more information, visit: www.healthpartnersipve.org