MEMORANDUM OF UNDERSTANDING

Between [DV AGENCY] and HEALTH CENTER/CLINIC]

This agreement is made by and between [DV Agency] and [health center/clinic] to identify survivors of IPV in the health care setting and to respond to their needs, including IPV-related health issues, safety concerns and connection to community IPV resources.

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

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

1) Representatives of [DV agency] and [health center/clinic] will meet each other at least once to understand the services currently provided by their respective programs and to discuss needs/goals and next steps.
2) Representatives of [DV agency] and [health center/clinic] will continue to meet *[list frequency and meeting location]*.
3) [Health center/clinic] will hold the following roles and responsibilities: routinely educate and screen patients for intimate partner violence (IPV), address IPV-related health issues, offer domestic violence [DV agency] contact information, and offer facilitated referrals to [DV agency].
4) [DV agency] will hold the following roles and responsibilities: training [Health center/clinic] providers and staff; serve as a primary referral for [Health center/clinic] patients in need and be available for phone referrals, which includes: build rapport, determine any immediate safety needs, do safety planning and create a follow-up plan with the patient.
5) [Health center/clinic] will provide the following resources: dedicated staff time; display of IPV awareness posters and other materials and [DV agency]; distribution of safety cards and contact info for DVSP.
6) [DV agency] will provide the following resources: dedicated staff and volunteer advocate time for referral calls; agency brochures.
7) No information will be shared by [DV agency] with [health center/clinic] or by [health center/clinic] with [DV agency] without written consent from the patient.

We, the undersigned, approve and agree to the terms and conditions as outlined in the Memorandum of Understanding.

By_____ By_____

Name _____ Name _____

Title _____ Title _____

Health center/clinic_____ DV Service Provider_____

Date_____ Date_____

This is a modified version of an MOU template was developed by the National Health Resource Center on Domestic Violence, a project of Futures Without Violence. 2016. For more information visit www.healthcaresaboutipv.org