County Health Department
Maternal Health Assurance Plan
Memorandum of Understanding - Sample Version

This plan outlines the **minimal** arrangement for assuring that all pregnant women who reside in ***County Name*** have access to prenatal services regardless of the ability to pay. *MOUs should not be considered ongoing. There should be information in the opening around the timeframe for the MOU.

Local Health Department Name will:

1. Provide pregnancy testing.
2. Refer Local Health Department (LHD) patients to ***Contracting Agency Name*** as the public health provider of maternal health services.
3. Provide a sliding fee scale (SFS) to be used for charges associated with patients without health insurance. Patients at or below 100% of the Federal Poverty Level will not be charged for prenatal services. There is no Title V specific sliding fee scale. (An example SFS can be found on the WHB website: https://wicws.dph.ncdhhs.gov/provpart/docs/SlidingFeeScaleFamilyPlanningClinics.pdf
4. Follow-up of positive pregnancy test to assure patient has access to healthcare provider.
5. Referral to WIC upon contacting patient.
6. Referral for Medicaid eligibility determination or completion of Presumptive Eligibility (PE) along with referral to a Care Manager for High-Risk Pregnancy.
7. Provision of patient/community maternal health education services within the authority of the LHD to promote health lifestyles.
8. Offer the 5A (ask, advise, assess, assist, arrange) method for tobacco cessation to all pregnant/postpartum patients.
9. Provide Postpartum/Newborn Nurse Home Visits to those patients who experience high-risk conditions during pregnancy.
10. Provide Spanish interpreter services at ***Contracting Agency Name*** for up to 8 hours per week.
11. Provide Spanish interpreter telephone coordination of care as needed to assure standard of care.
12. Will outline the duties of the LHD, if funds are exchanged.

Contracting Agency Name has agreed to provide maternal health services in their office and will:

1. Provide prenatal and postpartum care when applicable to facilitate access to early, continuous, quality care.
2. Assess patient's ability to pay, and charge fees based on SFS while assuring that no individuals will be denied service due to the inability to pay. Patients at or below 100% of the Federal Poverty Level will not be charged for prenatal services.
3. Provide patients with facility options for newborn delivery.
4. Referral to a high-risk clinic as appropriate for high-risk patients.

5. Referral back to the LHD for Family Planning services during or after the postpartum visit as applicable per the negotiated agreement.
6. Provide a description of how the LHD will be invoiced by the assuring agency, if funds are exchanged

Contracting Agency Name and the ***Local Health Department Name*** agree that services will be coordinated and assured to provide optimal care and outcomes for residents of _____County who are pregnant. The Local Health Department and partnering agency shall take measures to improve birth outcomes and the health status of women during pregnancy by following the program deliverables in the AA which have been put in place to help meet the yearly county-specific Outcome Objectives.

Should either party have questions or concerns, or require a change to this Memorandum of Agreement, written request should be given to the other party. Either party may terminate this agreement by giving (insert negotiated time here) written notice to the other party. This contract may not be amended, changed, modified, altered, or terminated except in writing.

It is understood and agreed that both parties shall operate independently, and that neither party shall be responsible for any acts or omissions of the other. Both parties agree to hold the other harmless from and against any, and all claims made for acts or omissions of the either party.

The undersigned certifies and warrants that he/she is duly authorized to sign on behalf of the CONTRACTOR.

By: _____

_____**(Contracting Agency)**

Date: _____

By: _____

_____

Health Director

_____**County Health Department**

Date: _____

Revised
03/2022Review