## MEMORANDUM OF UNDERSTANDING (MOU)

*between*

*Sauk County Community Care Voucher Program*

*and*

*[insert name of Dental Office]*

This is an agreement between the Sauk County Public Health Community Care Voucher program, hereinafter called The Voucher Program and “Party B”, hereinafter called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I. PURPOSE & SCOPE**

This document represents an agreement between Sauk County and the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dental office for the purpose of sharing patient information and having agreed upon terms for clients receiving a Dental Voucher from the Sauk County Community Care Program.

In particular, this MOU is intended to:

• Enhance understanding of the Sauk County Community Care dental voucher

• Provide clear expectations for both parties

**II. BACKGROUND**

The Voucher Program provides acute health care services for individuals with no health or dental insurance. Dental Vouchers are for acute dental needs. The extent of the service provided is determined by the dentist providing care. Eligible clients must be at or below 200% of the Federal Poverty Level and not have dental insurance.

**III. Sauk County Voucher Program RESPONSIBILITIES UNDER THIS MOU**

Sauk County shall undertake the following activities:

• Screen clients for eligibility – both financial eligibility and to assure the need is acute in nature

• Schedule initial dental appointment with client at participating dental office.

* Work with Dental Office to determine client needs following initial appointment. Services following initial consultation and evaluation ~~must~~ shall be approved by Sauk County Public Health.

**IV. [PARTY B] RESPONSIBILITIES UNDER THIS MOU**

[Party B] shall undertake the following activities:

* Provide acute dental services to clients who have a voucher from the Sauk County Voucher Program
* Communicate with Sauk County Public Health to determine client needs and assure that services are covered. Following initial consultation and evaluation, notify Sauk County Public Health of recommended treatment plan.
* Assure that the acute services come at no cost to client. All bills should be sent directly to the Sauk County Health Department. This includes, but is not limited to, interpretive services for clients who’s primary language is not English.
	+ If a client is to need interpretive services and your dental office does not, for other patients, include this as part of service, Sauk County Public Health will arrange for a phone interpreter, paid for by Sauk County Public Health.

**V. FUNDING**

This MOU does include the reimbursement of funds between the two parties. The Sauk County Community Care Program will reimburse [DENTAL OFFICE NAME] for approved dental services provided to clients with a dental voucher. Reimbursement will be 60% of the Median cost, as outlined in the American Dental Association Survey of Dental Fees.

**VI. EFFECTIVE DATE AND SIGNATURE**

This MOU shall be effective upon the signature of The Voucher Program and Party B authorized officials. It shall be in force from (date)\_\_\_\_\_ to (date) \_\_\_\_\_.

Parties agree to be bound by the terms and conditions in the attached Exhibit A

The Voucher Program and B indicate agreement with this MOU by their signatures.

**Signatures and dates**

[insert name of Party A] [insert name of Party B]

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 \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ Date Adapted from USDA.gov - http://www.nal.usda.gov/fsn/Guidance/mou\_example\_final.pdf