



FETAL, INFANT, CHILD, and MATERNAL MORTALITY REVIEW MEMORANDUM OF UNDERSTANDING BETWEEN

(Reviewing County)

AND

(Referral County)

Agreement to be effective _____ and will be updated as needed.
(Date)

GOAL:

To reduce the number of preventable fetal, infant, child, and maternal deaths in counties without Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) Teams by establishing a working relationship with these counties, and reviewing fetal, infant, child, and maternal deaths occurring in these counties.

PRINCIPLES:

1. Both counties are of equal status.
2. Services provided by _____ FICMMR Team (known as the Review Team) will be coordinated in a collaborative manner.
3. Determining the degree of preventability and recommendations for community action is the primary focus of the review team.
4. Respect for the autonomy of all member agencies, their policies and procedures, will be maintained.

FUNDING/ADMINISTRATION:

1. It is understood that reimbursement for review services is as follows:

2. The _____ (Review Team) will review fetal, infant, child, and maternal deaths

(20 weeks gestation to age 18 years) occurring in _____ county.
3. The _____ (Review Team or County) will complete the Fetal, Infant, Child Death Review Report and enter it into the National Child Death Review System (CDR). The Maternal Mortality Reports will be completed by _____ and sent to the Department of Public Health and Human Services for data entry.
4. Abstraction of medical information for review purposes will be completed as follows:

5. The _____ (Review Team) will determine the degree of preventability and provide suggestions to _____ (Referral County) for community actions aimed at reducing preventable deaths.

STATEMENT of COOPERATION:

In acknowledgment of the above, I, _____ (Referral County) will:

1. Participate in the review to the full extent possible or as agreed to and assist in securing services/information from appropriate agencies in my county.
2. Pledge to hold any received information confidential and be willing to sign a confidentiality statement at any review team meetings attended.
3. Review the community action suggestions and implement as able/appropriate for _____ (Referral County).
4. Work cooperatively with the _____ (Review Team) toward decreasing preventable deaths in _____ county.

See next page for Required Signatures from both Counties.

REQUIRED SIGNATURES:

SIGNATURE (**Referral** County – Please include Name, Title, Full Address, Phone, & Email *under* the signature line)

_____ Date _____

SIGNATURE (**Reviewing** County - Please include Name, Title, Full Address, Phone & Email *under* the signature line)

_____ Date _____