MAKA HOSPICE INC.
7120 Hayvenhurst Avenue Suite 112, Van Nuys, CA 91406
Tel: 818-786-0035 Fax: 818-786-0036 E-Fax: 818-697-9259

NEW EMPLOYEE REQUIREMENTS

- New Employee Packet
- Resume
- Copy of :
    - Professional License
    - CPR/BLS
    - Auto Insurance
    - Driver's License/State ID
    - Professional Liability Insurance
    - Diploma/Transcript
    - Social Security Card/ITN
- Certificates (optional but preferred)
- Educational In-Service (Minimum of 12hrs. required for CHHA; Educational In-Service from previous/recent employer is acceptable)
- Picture (digital file) for ID Badge - Email to info@makahospice.com

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APPLICATION FOR EMPLOYMENT

Maka Hospice, Inc. is an Equal Opportunity Company and considers all applications for Employment equally regardless of race, color, and creed, national origin, sex, age, religion, veteran status or any disability that is not job related.

PERSONAL INFORMATION

Applicant's Name (Last, First, Middle)		Today's Date
Address		Date of Birth
Social Security No.	Position Applied For	
Home Phone No.	Cell Phone No.	Email Address

WORK HISTORY

Company's Name (Present or most recent)	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name:		Title of Your Position:	
Describe Work Performed:			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name:		Title of Your Position:	
Describe Work Performed:			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name:		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Have you ever been fired or asked to resign from a job for any reason? (if yes, please explain)			

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EDUCATION			
High School Name	Location	Diploma	
College Name	Location	Years Attended	Degree
Graduate School	Location	Years Attended	Degree

ARE THERE ANY REASONS YOU WOULD BE UNABLE OR UNWILLING TO PERFORM ANY OF THE TASK REQUIRED BY THE JOB YOU ARE APPLYING FOR? (IF YES, PLEASE EXPLAIN)

_____

LIST THREE (3) PERSON WHO ARE FAMILIAR WITH YOUR WORK OR SCHOOL BACKGROUND (DO NOT LIST RELATIVES)

Name	**Occupation**	**Address**	**Telephone No.**	**Relationship**

HAVE YOU BEEN CONVICTED OF A FELONY WITHIN THE LAST SEVEN (7) YEARS?
(Conviction will not necessarily disqualify an applicant from employment) ☐Yes ☐No

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY_____

ADDRESS_____

TEL NO. _____

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AFFIDAVIT

I certify that my answers to the foregoing questions are true and correct and that I have not left out any significant information of any kind whatsoever. I understand that if I am employed, any false, incomplete, misleading or otherwise, incorrect statements made on this application form, any other company document, or during any interviews, may be grounds for my immediate discharge, regardless of when discovered.

I hereby, understand and acknowledge that unless otherwise defined by applicable law, any employment relationship with other organization is of an "at the nature", which means that I may resign at any time and that the company may discharge me any time, with or without cause, and with or without prior notice. Further, I understand that this "at will" employment relationship may not be changed by any written document, or by conduct, unless such change is specifically acknowledged in writing by the authorized division/subsidiary Administrator/Director of Nursing of this organization, and the writing condition of this affidavit.

I hereby authorize the Company to contact any entity or individuals it deems appropriate to investigate my employment history, character, and justifications, and give my full and complete consent to the companies and individuals revealing any and/or all information as a part of the investigation. In addition, I hereby waive my right to bring any cause of action against these companies or individuals for defamation, invasion of privacy, or any other reason because of their release of information. Applicant authorizes the use of a photocopy of this affidavit as authorization. I agree that If I am employed, I will abide by all the rules, regulations, and safety programs of the Company, as well as instructions I receive from my supervisor(s).

This application will be used by the Company to decide if you are to be hired, but its receipt does not imply that you will be employed. If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all Maka Hospice, Inc., property in my custody, including beeper, forms, nursing bag, and disposable patient supplies. Otherwise, the cost of any property not returned will be withheld from the amount due upon separation until the property is returned.

THANK YOU FOR YOUR TIME, EFFORT AND INTEREST IN JOINING OUR COMPANY

SIGNATURE OF APPLICANT _____ DATE _____

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VERIFICATION AND REFERENCE CHECK

Applicant Information

Applicant Name: _____ Date: _____
Last First M.I.

Position Applied for: _____

*I hereby authorize any individual, hospital, company or institution with whom I have been employed, to furnish **Maka Hospice, Inc.** with any information concerning therewith from all liability for any damage whatsoever incurred in furnishing such information.*

Signature of Applicant: _____ Date: _____

Previous Employment

Name of Contact: _____Title: _____

Company: _____ Phone No.: _____ Fax No.: _____

Address: _____

Was the applicant an employee of your company? Yes ____No____
What was the period of Employment? **Start Date**: _____**End Date**: _____
What were the applicant's responsibilities? _____
_____

Please rate the applicant on the following:

Attendance	❑Poor	❑Average	❑Above Average
Cooperation	❑Poor	❑Average	❑Above Average
Initiative	❑Poor	❑Average	❑Above Average
Job Knowledge	❑Poor	❑Average	❑Above Average
Tolerance with people	❑Poor	❑Average	❑Above Average

What was the applicant's reason for leaving? _____

Would you rehire this applicant? Yes___ No___

Verified by: _____ Date: _____

❑Via Phone Call

❑Via Fox

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VERIFICATION AND REFERENCE CHECK

Applicant Information

Applicant Name: _____ Date: _____
Last First M.I.

Position Applied for: _____

I hereby authorize any individual, hospital, company or institution with whom I have been employed, to furnish Maka Hospice, Inc. with any information concerning therewith from all liability for any damage whatsoever incurred in furnishing such information.

Signature of Applicant: _____ Date: _____

Previous Employment

Name of Contact: _____ Title: _____
Company: _____Phone No.: _____ Fax No.: _____ Address:
_____

Was the applicant an employee of your company? Yes ____No____
What was the period of Employment? **Start Date:** _____**End Date**: _____ What were the applicant's responsibilities?
_____
_____

Please rate the applicant on the following:

Attendance	☐Poor	☐ Average	☐ Above	☐ Avenge
Cooperation	☐ Poor	☐ Average	☐ Above	☐ Avenge
Initiative	☐ Poor	☐ Average	☐ Above	☐ Avenge
Job Knowledge	☐ Poor	☐ Average	☐ Above	☐ Avenge
Tolerance with people	☐ Poor	☐ Average	☐ Above	☐ Avenge

What was the applicant's reason for leaving? _____
Would you rehire this applicant? Yes___ No___

Verified by: _____ Date: _____

☐ Via Phone Call

☐ Via Fax

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Universal Precautions

TO BE USED IN THE CARE OF ALL PATIENTS

GLOVES

- For touching any patient's blood or body fluids
- For handling any soiled items
- For performing venipuncture
- Change after contact

GOWNS

- Worn during any procedure likely to generate splashing of blood of body fluids

MASKS AND PROTECTIVE EYE WEAR

- Worn during any procedure likely to generate droplets or body fluids

HANDS

- Wash immediately if contaminated with blood or body fluids
- Wash immediately after gloves are moved
- To prevent needle stick injuries, needles should not be recapped, purposely bent, broken or removed from disposable syringes or otherwise manipulated by hand.
- Disposable syringes and needles, scalpel blades and other sharp items should be placed into punctureresistant containers located as close as practical to the areas in which they were used.
- To minimize the need for emergency mouth-to-mouth resuscitation mouthpieces, resuscitation bags of other ventilation devices should be available for use in areas where the need for resuscitation is predictable.

EMPLOYEE NAME: _____

SIGNATURE: _____

DATE: _____

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COORDINATION OF CARE

It is the policy of Maka Hospice Inc., that the clinical staff shall be responsible for notifying physician and/or the office for every significant charge in patient's condition.

The following conditions must be reported to the attending physician once they are identified:

- Temperature of > 100 F
- Blood pressure SBP > 160 or < 90 DBP > 100 or < 100 or < 50, unless reporting parameters were established by attending physician.
- Blood sugar < 80 mg/dl or > 300 mg/dl unless specified by attending physician
- Signs and symptoms of hyper/hypoglycemia
- Presence of adventitious breath sounds cyanosis, and increasing SOB or respiratory rate of 24/min.
- Fainting Episodes
- Sudden changes in mental status/behavior, decreasing level of consciousness
- Falls with or without injury
- Visual changes, slurred speech, weakness and numbness of extremities
- Chest pain not relieved by NTG or rest
- Wound not responding to prescribed treatment regimen in 4 weeks.
- Bleeding from any orifice/impending signs and symptoms of shock, call 911
- Signs and symptoms of drug, food reaction such as itchiness, SOB, rash, palpitation, and/or confusion
- Signs and symptoms of drug toxicity any sub-therapeutic levels
- Any abnormal laboratory results
- Pulse < 60/min. or > 120/min.
- Unusual incidents and occurrences.

Any field staff is responsible for notifying the PMD/DPCS/Case Manager promptly (within 24 hours) of any significant change in the patient's condition or treatment plan (MD orders, need for other service, etc.)

Name of Employee: _____

Signature: _____ Date: _____

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CONFIDENTIALITY STATEMENT

I, _____, understand that in the performance of my duties as an employee of this Agency. I may have access to, and may be involved in the processing of patient information. I understand that I am obligated to maintain the confidentiality of this patient information at all times, both at work and off duty.

☐ I understand that violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subjected to legal action.

☐ I understand that I am not to interpret, discuss, or otherwise relay medical or personal information about the patients, unless necessary during the course of fulfilling my job duties.

☐ I certify by my signature that I have participated in orientation and training concerning the privacy and confidentiality considerations of member information.

Employee Name/Signature/Title: _____ Date: _____

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PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

As Hospice patient, you have the right to:

1. Be given information about your rights and responsibilities or receiving Hospice services
2. Have your property and person treated with respect.
3. Voice grievances regarding treatment and care that is or falls to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the hospice and not be subjected to discrimination or reprisal for doing so.

a. The agency personnel receiving the complaint will discuss, verbally or in writing, the grievance with the appropriate clinical supervisor within five days of the alleged grievance. The clinical supervisor will investigate the grievance within five days after the receipt of such grievance and will make every effort to resolve the grievance to the patient's/client's satisfaction.

b. If the grievance cannot be resolved to the patient's/client's satisfaction, the patient's/client's or his/her representative is to notify, in writing, the Executive Director/Administrator. The grievance must state the problem or action alleged and the date the clinical supervisor was notified. The Executive Director/ Administrator and/or designee will then investigate the grievance and contact the patient/client or their representative regarding the grievance in an attempt to resolve the differences.

c. If the patient/client feels his/her grievance has not been resolved after working with agency personnel, he/she will be encouraged to notify the state via state Hotline number.

4. Participate in the development of your Hospice plan and chose and maintain an attending physician.
5. Have confidentiality of your medical records maintained and to be informed of the agency's policies on Dissemination of Clinical Information.
6. Be advised before care is being initiated of the extent to which payment for the hospice services may be expected from Medicare or other resources, and the extent to which you may be responsible for costs, both verbally and writing.
7. Be informed in writing and orally of any changes in #6 as soon as possible, but no later than 30 calendar days from the date that the agency becomes aware of the change.
8. Be given complete and current information concerning your diagnosis, treatment, alternatives, risk and prognosis as required by your physician's legal duty to disclose and of any changes to the care/services being provided in terms and language you can reasonably be expected to understand and of any changes to the care/services being provided.
9. Have your family or guardian exercise your Patient's rights, when the patient has been judged incompetent.
10. Be given the necessary information so you will be able to give informed consent for your treatment prior to the start of any treatment.
11. Be given the appropriate and professional quality. Hospice services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap or age.
12. To be informed in advance about the care to be furnished, and of any changes in the care to be furnished, the frequency of visits, and the disciplines that will furnish care.
13. Be free from physical, mental, sexual and or verbal abuse and/or neglect, or exploitation.
14. Be given proper identification by the name and title of everyone who provides Hospice services to you.
15. A plan of Hospice that will be developed to meet your unique health care needs.
16. Be given an assessment and update of your developed Hospice plan.
17. Be given data privacy and confidentiality.
18. Review your local record at your request and have a right to choose whether to participate or not in research or clinical trials.
19. Be given information regarding anticipated transfer of your Hospice to another health care facility and/or termination of Hospice services to you.
20. Voice grievance with and/or suggest change in Hospice serviced and/or staff without being threatened, restrained or discriminated and confidentiality.
21. Refuse treatment within the confines of the law.
22. Be given information concerning consequences of refusing treatment.
23. To participate in any discussion concerning a conflict or ethical issue arising from care provided.
24. To be informed in writing and orally about the Advance Directives.
25. To have pain assessed, managed and appropriately treated.

As Hospice patient, you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies and other pertinent items.
2. Assist in developing and maintaining a safe environment.
3. Inform Hospice agency when you will not be able to keep a Hospice visit.
4. Participate in the development and update of your Hospice plan.
5. Adhere and follow instructions to your developed/updated Hospice plan.
6. Request further information concerning anything you do not understand.
7. Give information regarding concerns and problems you have, to a Hospice agency staff member.
8. Reporting unexpected changes in the patient's condition.
9. Providing feedback regarding services, needs and expectations, asking questions regarding care or services.
10. Understanding and accepting the consequences for outcome if the care, services, and/or treatment plan are not followed. 11. Showing respect and consideration for the organization's personnel and property. 12. Meeting financial commitments by promptly meeting any financial obligation agreed to the organization

Acknowledged By:

_____ _____

Employee Name/Signature/Title **Date**

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EMPLOYEES WILL NOT BE REPRISED FOR GOOD FAITH REPORTING OF POTENTIAL OR SUSPECTED VIOLATIONS.

ALL EMPLOYEES HAVE THE RIGHT TO CALL THE *STATE OF PUBLIC HEALTH* OR *THE JOINT COMMISION* FOR ANY CONCERNS, MAKE A COMPLAINT, WITHOUT BEING SUBJECT TO DISCRIMINATION OR REPRISAL TO:

California Department of Public Health
ADDRESS: 600 N. Commonwealth Ave. Suite 903, Los Angeles, CA 90005
CONTACT: Toll Free (800) 228 1019

The Joint Commission
ADDRESS: One Renaissance Blvd., Oakbrook Terrace, Illinois 60181
CONTACT: (800) 994-6610 E-MAIL AT: compalint@jointcommission.org

Name/Title/Signature of Hospice Representative _____

Date _____

Name/Title/Signature of Employee _____

Date _____

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EMPLOYEE HEALTH EXAMINATION

YES	NO	CONDITION	YES	NO	CONDITION
		Frequent or severe headache			Nervous trouble of any sort
		Dizziness or fainting spells			Any drug or narcotic habit
		Unconsciousness for any reason			Excessive drinking habit
		Eye Problem(s) (except glasses)			Attempted suicide
		Hay fever			Motion sickness requiring drugs
		Asthma			Military medical discharge
		Heart Problem(s)			Medical rejection from or for military service
		High or Low Blood Pressure			Rejection for life insurance
		Stomach Problem(s)			Admission to hospital
		Kidney Stones or Blood Urine			Record of traffic convictions
		Sugar or Albumin			Record or other convictions
		Epilepsy of fits			Other Illness

I have examined (Mr. / Ms.) _____ who is applying for the position of _____.

EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Pulse _____

PPD Test	Date Administered: _____ Date Read: _____	Result: Erythema = _____ mm Induration = _____ mm ☐ Negative ☐ Positive; Chest X-Ray Results_____

PHYSICAL EXAMINATION: Report of Physician

Eyes:_____ Lungs/Hearts/Breast(s):_____

Skin:_____

Ears:_____ _____

Extremities:_____

Mouth: _____ Back:_____ Nervous System:

Neck:_____ Abdomen:_____ _____

I have found no condition that appears to prevent him/her from performing the duties of the position applied for, with the exception or possible exception of the following:

_____

_____

MD Name/Signature _____ Date: _____

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TUBERCULOSIS SCREENING PROGRAM

Name/Title: _____ Date: _____

Routine annual chest x-ray is no longer recommended for asymptomatic skin-test “Positive” employees. Annual chest x-ray screening has been replaced by this document. It is more important that individuals be assessed for signs and symptoms that may be suggestive of tuberculosis.

Should you develop signs and symptoms of tuberculosis (listed below) AT ANYTIME, report promptly to your supervisor who will arrange for a chest x-ray and follow up.

This questionnaire is to protect the health of our employees and patients. All answers are confidentially handled by the Nursing Supervisor. Answer will not affect job status, consideration for advancement, or issues related to your employment. If your answers suggest the possibility of a problem, you may be contacted by the Supervisor to assist you in obtaining any necessary care.

	NO	YES
1. Do you have a cough that has lasted longer than three weeks?		
2. Do you have a fever that has lasted longer than three weeks?		
3. Have you coughed up blood?		
4. Are you losing weight without trying to do so?		
5. Are you having frequent night sweats?		
6. Have you experienced the following combination of systems?		
A. Fatigue, fever, weight loss, and night sweats		
B. Coughing, chest pain, blood-streaked sputum		

This information is correct to the best of my knowledge. I take full responsibility for immediately reporting any of the signs and symptoms of TB listed above to Nursing Supervisor.

Employee Signature_____ Date_____

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HEPATITIS B VACCINE POLICY

The Center of Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) recommend immunization for all healthcare workers in the high-risk category. As healthcare personnel who will be exposed to the patient's blood and body fluid, you will fall into this high-risk category.

The CDC immunization practices advisory committee recommends that, if you are NOT vaccinated, you should receive one dose of Hepatitis Immune Globulin Human (H_BIG) and begin a series of Hepatitis B Virus (HBV) vaccine.

I _____, acknowledge that I am at risk of exposure or have been
(Name)
unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the

Hospice will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

_____ request that I receive the Hepatitis vaccine.

_____ refuse the Hepatitis vaccine and HOLD HARMLESS THE HOSPICE. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

_____ provide written proof of immunity (attach)

_____ provide written proof of previous vaccination (attach)

_____ provide written proof of medical contraindication (attach)

Employee Name/Signature/Title: _____

Date: _____

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INFLUENZA/FLU VACCINATION ACCEPTANCE/DECLINATION FORM

FLU SEASON: _____

o I understand that due to my occupational exposure to respiratory illnesses, I may be at risk of acquiring Influenza/Flu infection. I have been given the opportunity to be vaccinated with the flu, at no charge to myself

Reason/s for Accepting: (*Please check all the applies*)

o Desire for self-protection
o Desire to protect patients/family members
o Previous receipt of influenza vaccine
o Perceived effectiveness of the vaccine
o Desire to avoid missing work
o Personal physician recommendation/Peer recommendation
o Belief that receiving influenza vaccine is a professional responsibility
o Access to vaccination/coverage and free of charge
o Belief that the benefits of vaccination outweighs the risk of side effects.
o Other: _____

CONSENT:

I, _____ (*Staff Name/Title*) voluntarily submit to MAKA HOSPICE and authorize to administer FLU VACCINE of 0.5 ml intramuscular to me for the purpose of immunizing against Influenza. I have reviewed, asked questions and understand the Vaccine Information Statement presented to me.

If Influenza Vaccine received, provide information below:

Type of Vaccine: _____ Lot#/ Expiration Date: _____
Site of Injection: _____ Given at/by: _____

---

o **I DECLINE** to receive a FLU Vaccination due to the following reasons: (*Please check all that applies*)
o Received the Influenza vaccine for this Flu Season _____
o Date of current Flu shot: _____ (Attached proof of Vaccine received)
o I get sicker if I have the vaccination
o Against my religious practice
o Other: _____

Furthermore, this is to certify that I have been provided information at a minimum, the influenza vaccine; nonvaccine control and prevention measures; and the diagnosis, transmission and impact of influenza

_____ _____
Print Name of Employee/Signature/Title Date

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LETTER OF ACCEPTANCE

Dear Mr. / Miss/ Mrs. _____

In signing this contract, you are accepting the Position and at the rate of compensation described below.

MAKA HOSPICE, INC. offers you the following:

Position: _____
Status: ☐ Per Diem ☐ Full Time ☐ Part Time
Rate: _____ / hour _____ /visit Other/s: _____
To start on: _____

Any concerns that you may be directed to the Governing Board.

Sincerely,

_____
Representative of Governing Board

I agree to the above terms and to the Policies and Procedures of Maka Hospice, Inc.

_____ _____
Employee Name/Signature/Title Date

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HAND HYGIENE MONITORING TOOL

PERFORMANCE CRITERIA	YES	NO	N/A
Upon entering the patient's home			
Before direct contact with patient(s)			
Before touching clean supplies inside bag after each patient contact			
After removing glove, between gloves changes			
After contact with patient's intact skin (when assessing patient's PR, BP or after lifting patient or any direct care)			
After contact with blood, body fluids, mucous membranes, non-intact skin and wound dressings			
Before handling medications or food			
Before donning sterile gloves			
Before handling invasive device for insertion 9Foley catheter insertion, PICC line dressing change, others)			
Before leaving patient's home			
ADDITIONAL COMMENTS:			

Employee Name/Signature: _____

Evaluator Name/Title/Signature: _____

Date Observed: _____

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CONFLICT OF INTEREST STATEMENT

MAKA HOSPICE, INC. Policy and Procedures on Conflicts of Interest states that if a conflict on interest exists when there is a disjuncture between staff personal interests, financial or otherwise, or a professional interest, and his/her fiduciary obligations to the organization. Conflict of Interest Policy is attached. Please provide the following information:

1. I am currently involved in the following: (please list or indicate "none")

    a. Employment

    b. Partnership or controlling interest in the following business or other commercial activities.

    c. Directorships

2. I confirm that I have recently read the MAKA HOSPICE, INC. policy, guidelines and procedures on conflict of interest and understand that it is my responsibility to avoid conflicts of interest and to make full, timely and ongoing disclosure of conflicts when they arise.

3. I understand that I have a continuing obligation to update the information in this statement and agree that I will do so when any circumstances change.

4. Any additional information you wish to provide:

Employee Name/Signature/Title: _____ Date: _____

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FRAUD & ABUSE POLICY

Hospice providers have an obligation, under law to conform to the requirements of the Medicare program. Fraud and abuse committed against the Medicare program may be prosecuted under various provisions of the US Code and may result in the imposition, fines and in some instances, imprisonment. In addition, administrative sanctions and civil penalties may be imposed.

Fraud is defines as intentionally, knowingly and willfully making false statements or representations of material facts in order to obtain benefit or payment for which no entitlement would otherwise exist.

Examples of fraud include, but are not limited to:

- Billing of services not provided
- Altering claims to receive higher payments
- Duplicate billing
- Offering, paying, soliciting or receiving bribes, kickbacks and/or rebates
- Misrepresenting the services provided, i.e. describe non-covered services in a way that allows Medicare to cover services.

Abuse constitutes practices that, either, directly or indirectly, result in unnecessary costs to the Medicare program. Although abuse may appear similar to fraud, abusive acts are not committed knowingly, willfully or intentionally.

The (3) three stands CMS uses when judging if abusive acts in billing are committed are:

1. Medical necessity
2. Conformity to professionally recognized standards
3. Friar price

Examples of abuse including but are not limited to:

- Charging excessive amounts for services
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medicare based on the higher fees schedule that for non-Medicare patients
- Submitting bills to Medicare that are the responsibility of other insurers
- Violating the provider participation agreement

This Hospice supports all efforts to protect Medicare from instances of fraud and/or abuse. Any employee found to be guilty of acts of fraud and/or abuse will be subject to disciplinary action which may include but is not limited to termination of employment.

My signature acknowledges receipt and understanding of Fraud and Abuse Policy of Maka Hospice, Inc

_____ _____

Print Name of Employee/Contractor Signature/Title Date

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ORIENTATION CHECKLIST

_____ 1. Introduction to Office Staff

_____ 2. Service Agreement and Position Description

_____ 3. Documentation and Forms

_____ 4. Agency Policies and Procedures

_____ 5. Personnel Policies

_____ 6. Illness and Injury Prevention Program

_____ 7. Infection Control

_____ 8. Function of and Referral to Other Disciplines

_____ 9. Title XXII, Chapter 6 and Medicare Conditions of Participation

_____ 10. Reporting of Significant Changes in the Patient's condition

_____ 11. Case Conferences

_____ 12. In-Service Education

_____ 13. Quality Management Program

_____ 14. Patient/ Staff and Agency Confidentiality

_____ 15. Fire Safety/Emergency Preparedness

_____ 16. Employee Handbook

Acknowledgment:

1. *I have been oriented to the above.*
2. *I have received a copy of my position description.*
3. *I have completed orientation.*

Employee Name/Signature/Title: _____ Date: _____

Agency Representative Signature: _____ Date: _____