様式第7号

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| **介護保険〔要介護認定・要支援認定〕申請書** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | 新規 | | | |  | | | 更新 | | | | | | | |  | | | 要介護状態・要支援状態区分変更 | | | | | | | | | | | | | | | | | | | | | | | |  | | | | 転入による | | | | | | | | | | | | | | | |
| 該当するものにレ印を付けてください。  (宛先)所沢市長  　　次のとおり申請します。　　　　　　　　　　　申請年月日　　　　　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 被保険者 | 被保険者番号 | | | | | | | | | | |  | |  |  | | |  | |  |  |  |  | |  | |  | | | | 個人番号 | | | |  | |  | |  | | |  | | | |  | | |  | | |  |  | | |  |  |  | |  | |  |
| フリガナ | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | 生年月日 | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 氏名 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| 住所 | | | | | | | | | | | 所沢市 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自宅電話番号 | | | | | | | | | | | (　　　 ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| その他連絡先 | | | | | | | | | | | (　　　 ) | | | | | | | | | | | | | | | | | | 氏名 | | | |  | | | | | | | | | | | | | | 続柄 | | | | | | |  | | | |  | | |
| 現在の要介護認定の結果等  ＊更新・変更・転入申請の場合のみ記入 | | | | | | | | | | | 要介護状態区分　１　２　３　４　５　　要支援状態区分　１　２ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 有効期間：　　 年　　　月　　　日から　　 年　　　月　　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※転入の場合に記入　転入前の保険者名〔　　　　　　　　　　　　〕  　要介護・要支援認定を申請中ですか。〔 　はい　 ・ 　いいえ 　〕 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医療保険 | 保険者名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | 保険者番号 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  |
| 被保険者  記号・番号 | | | | | | | | | | 記号 | | | | |  | | | | | | | | | 番号 | | | | | | |  | | | | | | | | | | | | 枝番 | | | | | | | | |  | | | | | | | |  |
| 申請の理由 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 入院・入所の状況 | | | | | | | | | | | 名称等　　　　　　　　　　　　　　　　　　　（　　　　　　　病棟） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 期間 | | | | | | | | | | | 年　　月　　日～入院中(　　　　年　　月　　日に退院予定) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 介護サービス計画の作成等介護保険事業の適切な運営のために必要があるときは、要介護認定・要支援認定に係る調査内容、介護認定審査会による判定結果・意見及び主治医意見書を所沢市から地域包括支援センター、居宅介護支援事業者、居宅サービス事業者若しくは介護保険施設の関係人、主治医意見書を記載した医師又は認定調査に従事した調査員に提示することに同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | 本人氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | (代筆者氏名：　　　　　　　続柄：　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | 提出代行者 | | | | 氏名 | | | | | | |  | | | | | | | | | | | | | 続柄 | | | | | | | |  | | | | 電話番号　　（　　　） | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 住所　〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 提出代行  事業所名 | | | |  | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | ※次の中から該当する事業所の番号を記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| １地域包括支援センター　／２指定居宅介護支援事業者　／３指定介護老人福祉施設  ４介護老人保健施設　／５介護医療院　／６その他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 名称 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 担当： | | | | | | | | | | | |
| 住所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 電話番号　　（　　　） | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 主治医 | | | | 医療機関 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | 主治医氏名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
| 所在地 | | | | | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 第2号被保険者(40歳から64歳までの医療保険加入者)のみ記入 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 特定疾病 | | |  | | | | | | (疾病名) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | 受付者 | | | | | | | | | | |  | | | | | | | | | |  | |
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