様式第1号

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| 介護保険 | | | | | | | | | | | | | | | | | | 要介護・要支援  新規・更新・変更 | | | | | | | | | | 認定申請書 | | | | | | | | | | | | | | | | | | | | | |
| 佐賀県東松浦郡玄海町長　様  　次のとおり申請します。　　　　　　　　　　　　　　　　　　　　　申請年月日　　　　　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 被保険者 | 介護保険被保険者番号 | | | | | | |  |  |  | |  | |  |  | | |  |  |  | |  | 個人番号 | | | | | |  |  | |  |  |  | | | |  |  | |  | |  |  |  |  |  | |
| 医療保険 | 保険者名 | | | | | |  | | | | | | | | | | | | | 保険者番号 | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 被保険者証 | | | | | | 記号 | | |  | | | | | | | | | | 番号 | | |  | | | | | | | | | | | | 枝番 | | | | | |  | | | | |
| フリガナ | | | | | | |  | | | | | | | | | | | | | | | 生年月日 | | | | | | 明・大・昭　　　年　月　日 | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | |  | | | | | | | | | | | | | | |
| 性別 | | | | | | 男・女 | | | | | | | | | | | | | | | | | |
| 住所 | | | | | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 前回の要介護認定の結果等 | | | | | | | ※要介護・要支援更新認定の場合のみ記入 | | | | | | | | 要介護状態区分　12345　　　　要支援状態区分　12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 有効期限　　　　年　　月　　日　から　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※14日以内に他自治体から転入した者のみ記入 | | | | | | | | 転出元自治体〔市町村〕名　〔　　　　　　　　　　　　　　〕  現在、転出元自治体に要介護・要支援認定を申請中ですか。  (既に認定結果通知を受け取っている場合は「いいえ」を選択してください)　　はい・いいえ  「はい」の場合、申請日　　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 変更申請の理由 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 過去6月間の介護保険施設、医療機関等への入院、入所の有無  ※（有・無）該当に○ | | | | | | | 〔介護保険施設・医療機関・他〕名称・所在地 | | | | | | | | | | | | | | | | | | | | 期間　　年　月　日～　年　月　日 | | | | | | | | | | | | | | | | | | |
| 〔介護保険施設・医療機関・他〕名称・所在地 | | | | | | | | | | | | | | | | | | | | 期間　　年　月　日～　年　月　日 | | | | | | | | | | | | | | | | | | |
| 〔介護保険施設・医療機関・他〕名称・所在地 | | | | | | | | | | | | | | | | | | | | 期間　　年　月　日～　年　月　日 | | | | | | | | | | | | | | | | | | |
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|  | 申請者 | | | | | | | フリガナ | | | | | | | | | | | | | | | | | | | 被保険者との関係 | | | | | | | | |  | | | | | | | | | | | | |  |
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| 申請者住所 | | | | | | | 〒  電話番号　　　　　　　　(　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 提出代行者 | | | 名称 | | | | 該当に○(地域包括支援センター・居宅介護支援事業所・指定介護老人福祉施設・介護老人保健施設・介護医療院) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 主治医 | | | | | 主治医の氏名 | | | | | | | |  | | | | | | | | | | | | 医療機関名 | | | | | |  | | | | | | | | | | | | | | | |  | |
| 所在地 | | | | | | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 第2号被保険者(40歳から64歳の医療保険加入者)のみ記入 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 特定疾病名 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 介護サービス計画又は介護予防サービス計画を作成するために必要があるときは、要介護認定・要支援認定にかかる調査内容、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、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、保険給付対象外のサービス事業者等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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 本人氏名又は名称 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 被保険者との関係(　　　　　　　　　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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