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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・変更　）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 長崎県西海市長　様  次のとおり申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ●要介護認定を受ける方についてご記入下さい。　　　　　　記入年月日　　　　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被　　保　　険　　者 | 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 | | | | 年　 　月　 　日 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　名 | | | | | |  | | | | | | | | | | | | | | | 性　別 | | | | 男 ・ 女 | | | | | | | | 世帯主 | | | | | | | | | | |  | | | | | | | |
| 住　所 | | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| ＴＥＬ | | | | | | | | | | | | | | | | | | | | | | | | ひとり暮らし　・　高齢者のみ | | | | | | | | | | | | | | | | | | | | | |
| 前回の要介護認定の結果等 | | | 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　～　　　　年　　　月　　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※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。  （既に認定結果通知書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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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、介護保険施設、主治医意見書を記載した医師又は認定調査に従事する調査員に提示することを同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 本人氏名　　　　　　　　　　　　　代筆者氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ●代理・代行の方が申請される場合ご記入下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 代理・代行申請者 | 氏　名  名　称 | | | | | 該当に○(代理申請・居宅介護支援事業者・指定介護老人福祉施設 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (代理申請の場合）  本人との続柄 | | | | | | | | | | | |
| ・介護老人保健施設・指定介護療養型施設・介護医療院) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 【代行申請の場合は申請担当者氏名：　　　　　　　　　】 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住　所 | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| ＴＥＬ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 委任欄 | | | | | 上記（申請者）の者がこの要介護等認定申請書を提出することを委任します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請者が本人以外の場合必要です。 | | | | | 被保険者住所 | | | 〒 | | | | | | | | | | | | | | | 氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （記名押印又は自筆による署名のいずれかとしてください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ●調査では、ご家族や介護者の方にご本人の状態をお聞きします。日頃の状態をご存知な方の同席をお願いします。連絡先については、確実に連絡のとれる時間帯及び電話番号をご記入下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 同　席　者 | フリガナ | | | | |  | | | | | | | | | | | | | | | | | 本人との続柄 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 氏　名 | | | | |  | | | | | | | | | | | | | | | | |
| 住　所 | | | | | 〒 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 連　絡　先 | | | | | 【連絡のとれる時間帯及び電話番号】 | | | | | | | | | | | | | | | | | | | | | | 自宅・勤務先（　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | |
| ：　　～　　：　　　ＴＥＬ | | | | | | | | | | | | | | | | | | | | | | その他（　　　　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | |
| ●要介護認定を受ける方の主治医をご記入下さい。主治医がいない方は長寿介護課へご相談下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主治医 | | フリガナ | | | | |  | | | | | | | | | | | | | 医療機関名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主治医氏名 | | | | |  | | | | | | | | | | | | |
| 所　在　地 | | | | | 〒 | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | ＴＥＬ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ●2号保険者(４０歳から６４歳の医療保険加入者)の方はご記入下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 特定疾病 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ●調査場所に○印をつけて下さい。居住地以外の場合は名称・所在地を記入して下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 【調査場所】居住地・入院施設・入所施設・住民票の住所と異なる住宅等  (入院・入所期間　　．　　．　　～　　．　　．　　)  【名　　称】  【所在地】  　　　　　　　　　　　　　　　　ＴＥＬ | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | 調査可能な曜日・時間帯 | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | |  | | | | 月 | | | | | 火 | | | 水 | | | | | 木 | | 金 | |
|  | | | | 午前 | | | |  | | | | |  | | |  | | | | |  | |  | |
|  | | | | 午後 | | | |  | | | | |  | | |  | | | | |  | |  | |
|  | | | | ○印をお願いします。 | | | | | | | | | | | | | | | | | | | | | | | | | |
| ●今回の申請について、連絡事項がありましたらご記入下さい。※変更申請は理由をご記入下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 連絡事項 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |