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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・転入）  江　田　島　市　長　様  次のとおり申請します。 　　　　　　　申請年月日　令和　　年　　月　　日   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 申請者氏名 | |  | | | | | | 本人との関係 | | | | | |  | | | | | | | | | | | | | 申請代行者  名　　　称 | | 該当に○（地域包括支援センター・居宅介護支援事業者・指定介護老人福祉施設・介護老人保健施設・指定介護療養型医療施設，介護医療院） | | | | | | | | | | | | | | | | | | | | | | | | | 申請者住所 | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | 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  歳 | | | | | | | | | | | 性　別 | | | | | | | 被保険者氏名 | |  | | | |  | | | | | | | 住所 | | 〒 | | | | | | | | | 電話番号 | | | | | | | | | | | | | | | | 訪問先住所  (住所と違う場合) | | 〒 | | | | | | | | | 電話番号 | | | | | | | | | | | | | | | | 前回の要介護  認定の結果等 | | 更新認定の場合のみ記入 | | 要介護・要支援状態区分 | | | | | | | | | | | | | | | | | | | | | | | 有効期限　　　　年　　月　　日　～　　　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。  はい (申請日　　　　　　　年　　　月　　　日) ・ いいえ | | | | | | | | | | | | | | | | | | | | | | | 変更申請理由  (変更申請のみ記入) | |  | | | | | | | | | | | | | | | | | | | | | | | | | 入院・入所施設名 | | 名称・所在地  　　　　　　　　　　　　　　　　　　　　　　　　年　　月　　日～　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | 名称・所在地  　　　　　　　　　　　　　　　　　　　　　　　　年　　月　　日～　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | 主　治　医 | | 診療科・氏名 | | |  | | | | | 医療機関名 | | | | | |  | | | | | | | | | | | 所　在　地 | | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | |   ２号被保険者（40歳から64歳の医療保険被保険者）のみ記入   |  |  | | --- | --- | | 特定疾病名 |  |   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江田島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。  被保険者氏名　代筆者氏名  ※認定調査立会者氏名　　　　　 　 　　　 代筆者住所  ※電話番号 　　　 　　 　 本人との関係 |