|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **介護保険要介護認定・要支援認定区分変更申請書**  受付印  （申請日）  我孫子市長あて　次のとおり申請します。   |  |  | | --- | --- | | **申請区分**  ＊必ず☑ | **□ 新規　　□ 更新　 □ 区分変更　　□ 転入継続** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **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** | |  | | | | | | | | | | | | | | | **記号** |  | | | | | | | **番号** | | | |  | | | | | | | **枝番** | | | |  | | | | | | | | **＊医療保険被保険者証（健康保険証）（写し可）の提示が必要となります。** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **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**  ※更新・区分  変更の方 | | 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　　 令和　　　　年　　　　月　　　　日　　から　　 令和　　　　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：　令和　　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | **提出代行者**  **該当に○** | | | 高齢者なんでも相談室（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・  指定介護養型医療施設・介護医療院  　名　　称　　　職員名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **申請理由** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |   **■審査会の資料となる「主治医意見書」の作成を依頼する医療機関**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **医療機関名** |  | | | **診療科：**  **医師名：** | | **所在地** | 〒　電話番号 | | | | **定期受診** | 有　・　無　・　入院中 | **受診日** | 前回　　　　年　　　月　　　日 | 次回　　　年　　　月　　　日 |   **■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** |  | |

様式第28号

**介護(介護予防)サービス計画を作成するために必要がある時は、要介護（要支援）認定の調査内容、認定審査会による判定・意見及び主治医意見書を、市から地域包括支援センター（高齢者なんでも相談室）、居宅介護支援事業者、介護保険施設関係者、居宅サービス事業者等若しくは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。**

**本人との関係**

**本人氏名　　　　　　　　　　　　　　　　　　※代筆者氏名　　 　　　　　　　　　　（　　　　　　　 ）**

**裏面あり⇒**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **■認定調査確認票**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **調査実施場所**  **（住所地以外の**  **場合に記入）** | | 施設名等 | | 医療機関・介護保険施設・その他    　　　　　　　　　　　　　　　　　　　　　　（　　　階　　　　　　病棟　　　　　号室　） | | | | | | 住　　所 | | 〒  　　　　　　　　　　　電話番号 | | | | | | **予定** | ●ご都合の悪い曜日がありましたら、下の表に**×印をご記入**ください。 | | | | | | | | |  | | 月 | | 火 | 水 | 木 | 金 | | 午前 | |  | |  |  |  |  | | 午後 | |  | |  |  |  |  | | ≪備考≫ | | | | | | | | | **日時**  **調整先**  **・**  **立ち会い** | ●月～金で、日中（8：30～17：00）連絡の取れる連絡先をご記入ください。 | | | | | | | 調査  立ち会い | | 1. 氏名　　　　　　　　　　　　　　　　　　　　　　（続柄）   　　 電話番号   1. 氏名　　　　　　　　　　　　　　　　　　　　　　（続柄）   　　　電話番号 | | | | | | | 有・無  有・無 | | ●上の連絡先への電話で、都合が悪い曜日・時間帯がありましたらご記入ください。 | | | | | | | | | **別室での**  **聞き取り希望** | （　 　**する　 　・　 　しない**　 　　） | | | | | | | | | **調査員の**  **駐車スペース** | 無　　・　　有　　（場所　　　　　　　　　　　　　　　　　　　　　　　　　　 　　） | | | | | | | | | **被保険者本人の健康状態**  ※  特別な配慮の必要がありましたら必ずご記入ください。 | ●病名（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　）  ●本人に告知していない病名　（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　 　　　　）  ●入院中の方（入院時期：　　　　　年　　　月　　　日　～　　　　年　　　月　　　　日　）  　　　□手術をした、または予定している　（ 　　　年　　　月　　　日　）　（手術部位：　　　　　　　　）  　　　□リハビリを開始している  　　　□退院は未定  　　　□退院予定あり　（ 　　 　年　　　月　　　日　）  □転院予定あり　（ 　　 　年　　　月　　　日　）　転院先（ 　　　　　　　　　　　　　　　　　　　 ）  ●その他 | | | | | | | | | **＊訪問日時は、我孫子市職員又は市が調査を委託した事業者から電話連絡します。** | | | | | | | | | |

高齢者支援課処理欄（下欄は記入しないでください）

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 受付者 | 身元確認書類 | 個人番号カード |  | 成年後見人等確認 | 後見人・保佐人・補助人の身分証 |  | 確認者 |
|  | 介護保険被保険者証・負担割合証 |  | 登記事項証明書 |  |  |
| 運転免許証・健康保険証 |  | 代理行為目録（保佐人・補助人は必要） |  |
| その他（　　　　　　　　　　　　） |  | その他（　　　　　　　　　　　　　　　） |  |
| 連絡事項 | |  | 被保険者証 | | * 回収 | | |