様式第15号(第16条関係)

保険証回収　済・未

資格者証発行　済・未

サービス計画　済・未

介護保険料　済・未

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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　　□区分変更(要支援者の要介護新規申請含む)  　(あて先)北茨城市長 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | 年　　月　　日 | | | | | | | | | | | | | | |
| 氏名 | | |  | | | | | | | | | | | | | | |
| 性別 | | | | | 男・女 | | | | | | | | | | | | | | |
| 住所 | | | 〒  電話番号  日中の連絡先 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 前回の要介護認定の結果等 | | | 要介護状態区分12345　　　要支援状態区分12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 有効期間　　　　　　年　　月　　日から　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 変更申請の理由 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 現在いる場所  (現住所以外の場合のみ、ご記入ください) | | | □介護保険施設に入所中 | | | | | | | | | 施設・医療機関名 | | | | | | | | |  | | | | | | | | | | | | | | | | |
| □一般病院等に入院中 | | | | | | | | | 退院・退所の予定 | | | | | | | | | 未定・あり(　年　月　日ごろ) | | | | | | | | | | | | | | | | |
| □その他の場所 | | | | | | | | | 住所 | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 名前 | | | | | | 様方 | | | | | | | | | | | | | | | | | | | |
| 電話番号 | | | | | |  | | | | | | | | | | | | | | | | | | | |
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|  | 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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 住所 | | 〒  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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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、北茨城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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 代理人氏名 | | |  | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | |  |
| 続柄 | | |  | | | | | | | | | | | | | 本人氏名 | | | | | | |  | | | | | | | | | | | | | | | |  |
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