|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 介護保険　要介護認定・要支援認定区分変更申請書  天　塩　町　長　　様  　次のとおり申請します。   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | | | | 申請年月日 | 令和　　年　　月　　日 | | | | | | | | | | | | | | 被　　　保　　　険　　　者 | 被保険者番号 |  |  |  |  |  |  |  |  |  |  | 個人番号 |  | |  |  |  |  |  |  |  |  |  |  |  | | フ リ ガ ナ |  | | | | | | | | | | 生年月日 | 明・大・昭・令  　 　　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　　１　 ２　 ３　 ４　 ５  要支援状態区分　　１　 ２ | | | | | | | | | | | | | | | | | | | | | | | | | 有効期間　　　　　 　年　 　月　 　日から　　　 　年　 　月　 　日 | | | | | | | | | | | | | | | | | | | | | | | | | 変更申請の理由 |  | | | | | | | | | | | | | | | | | | | | | | | | | 過去６ヶ月間の介護保険施設・医療機関等入院入所の有無 | 名称等  介護保険施設の  　　　　　　　所在地 | | | | | | | | | | | | 期間　 年　 月　 日～　 年　 月　 日 | | | | | | | | | | | | | 名称等  介護保険施設の  　　　　　　　所在地 | | | | | | | | | | | | 期間　 年　 月　 日～　 年　 月　 日 | | | | | | | | | | | | | 名称等  医療機関等の  　　　　　　　所在地 | | | | | | | | | | | | 期間　 年　 月　 日～　 年　 月　 日 | | | | | | | | | | | | | 有　・　無 | 名称等  医療機関等の  　　　　　　　所在地 | | | | | | | | | | | | 期間　 年　 月　 日～　 年　 月　 日 | | | | | | | | | | | |  |  |  |  | | --- | --- | --- | | 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）  印 | | 住 所 | 〒  電話番号 |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | 主治医 | 主治医の氏名 |  | 医療機関名 |  | | 所 　在 　地 | 〒  電話番号 | | |   ２号被保険者（40歳から64歳の医療保険加入者）のみ記入   |  |  |  |  | | --- | --- | --- | --- | | 医療保険者名 |  | 医療保険被保険者証記号番号 |  | | 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天塩町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。  　　　　　　　　　　　　　　　　　　　　　　　　　　　　　本人氏名 |