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| **介護予防サービス計画作成依頼（変更）届出書**  **介護予防ケアマネジメント依頼（変更）届出書**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 区　　　分 | | | | | | | | | | | 新規・変更 | | | | | | | | | | | 被保険者名 | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | フリガナ | | | | | |  | | | | |  | | |  | | |  | | | | |  | | |  | | |  | | | | |  | | |  | |  | | |  | | | | | | 個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | | | |  | |  | |  | | | |  | | |  | | |  | |  | | 生年月日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年 　　　月 　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 介護予防サービス計画の作成又は介護予防ケアマネジメントを依頼（変更）する事業者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所名 |  | | | | 事業所の所在地 | | | | | | | | | | | | | | | | 〒 | | | | | | | | | | | | | | | | | | | |  | | | | | 電話番号　　　（　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 介護予防支援又は介護予防ケアマネジメントを受託する居宅介護支援事業者  ※居宅介護支援事業者が介護予防支援又は介護予防ケアマネジメントを受託する場合のみ記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所名 |  | | | | | | 事業所の所在地 | | | | | | | | | | | | | 〒 | | | | | | | | | | | | | | | | | | | | |  | | | | | | | 電話番号　　（　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 事業所を変更する場合の事由等 | | | ※変更する場合のみ記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 変更年月日（ 年 月 　 日 付) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 行方市長 様  上記の指定介護予防支援事業者に介護予防サービス計画又は介護予防ケアマネジメントの作成を依頼することを届け出ます。  年 月 日  住所  被保険者  氏名 　　　　　電話番号　　　（　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 保険者確認欄 | | □ 被保険者 □ 届出の重複  □ 指定介護予防支援事業者番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | |  | |  | | |  | | |  | | |  | | | | |  | |  | | |  | | |  | | |  | | | | |   **介護予防サービス計画又は介護予防ケアマネジメントの作成を依頼（変更）する指定介護予防支援事業者が介護予防支援の提供にあたり、被保険者の状況を把握する必要がある時は、要介護認定・要支援認定に係る調査内容、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当該介護予防支援事業者に必要な範囲で提示することに同意します。**  **年 　月 　日 氏名**  **（注意） １ この届出書は、要支援認定の申請時、若しくは、介護予防サービス計画の作成又は介護予防ケアマネジメントを依頼する事業所が決まり次第速やかに行方市へ提出してください。**  **２ 介護予防サービス計画の作成又は介護予防ケアマネジメントを依頼する事業所を変更するときは、変更年月日を記入のうえ、必ず行方市に届出してください。届出のない場合、サービスに係る費用を一旦、全額自己負担していただくことがあります。** |