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| **居宅サービス計画作成依頼（変更）届出書**  契約日を記入してください  新規認定申請中、区分変更中の場合は、要介護度が  確定してから届出をしてください   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **記入例** | | | | | | | | | | | | | | | | | | | | | | | 区　　　分 | | | | | | | | | 新規・変更 | | | | | | | | | 被保険者氏名 | | | | | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | | | | | | フリガナ | | | | | | | | | |  | |  | |  | |  | |  | | |  | |  | |  | |  | |  | | | 個人番号が不明の場合等は空欄のままで提出してください | | | | | | | | | | 個人番号 | | | | | | | | | | | | | | | | | | | | | |  |  | |  | |  | |  | |  | |  |  | |  | |  | |  | |  | | 生年月日 | | | | | | | | | | | | | | | | | | | | | | 年 　　　月 　　日 | | | | | | | | | | | | | | | | | | | | | | 居宅サービス計画の作成を依頼（変更）する居宅介護支援事業者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 居宅介護支援事業所名 | | | | |  | | | | | 居宅介護支援事業所の所在地 | | | | | | | | | | 〒 | | | | | | | | | | | |  | | | | | | | | | | 電話番号　　　（　　） | | | | | | | | | | | | | | | | | | | | | | 居宅介護支援事業所番号 | | | | | | | | | | サービス開始（変更）年月日 | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | 居宅介護支援事業所を変更する場合の理由等 | | | | | | | | | | | ※変更する場合のみ記入してください。 | | | | | | | | | | | | | | | | | | | | | 契約日を記入してください | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 行方市長 様  上記の居宅介護支援事業者に居宅サービス計画の作成を依頼することを届け出ます。  年 月 日  市に提出する日を記載してください  住所　〒  被保険者  氏名 　　　　電話番号　　　（　　）  **居宅サービス計画の作成を依頼（変更）する居宅介護支援事業者が居宅介護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居宅介護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、要介護認定の申請時、又は居宅サービス計画の作成を依頼する居宅介護支援事業所が**  **決まり次第速やかに行方市へ提出してください。**  **２ 居宅サービス計画の作成を依頼する居宅介護支援事業所を変更するときは、変更年月日を記入のうえ、**  **必ず行方市に届け出てください。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。**   |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 保険者確認欄 | □ 被保険者資格 □ 届出の重複  □ 居宅介護支援事業者事業所番号 | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  | |