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|  | | | | | | 地域生活支援事業　支給申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 長久手市福祉事務所長　殿 | | | | | | | | | | | |  | | | | | | | | | | | | | | 申請年月日 | | | | | | | | | 年 月 日 | | | | | |
| 次のとおり申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申　請　者 | | フリガナ | | | | |  | | | | | | | | | | | | 生年月日 | | | | | | | | 年 月 日 | | | | | | | | | | | | | |
| 氏名 | | | | | 印  個人番号： | | | | | | | | | | |  |
| 居住地 | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| フリガナ | | | | | | |  | | | | | | | | | | | | 生年月日 | | | | | | | | 年 月 日 | | | | | | | | | | | | | |
| 支給申請に係る児童氏名 | | | | | | | 個人番号： | | | | | | | | | | | |
| 続　柄 | | | | | | | |  | | | | | | | | | | | | | |
| 身体障害者  手帳番号 | | | | | | |  | | | | | | | | | | | | 精神障害者保健  福祉手帳番号 | | | | | | | | | | | |  | | | | | | | | | |
| 療育手帳番号 | | | | | | |  | | | | | | | | | | | | 自立支援医療  (精神)番号 | | | | | | | | | | | |  | | | | | | | | | |
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| サービス利用の状況 | 地域生活支援  福祉サービス | | | | 利用中のサービスの種類と内容等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護給付  訓練等給付 | | | | 障害支援  区分の認定 | | | | 有・無 | | | | | 区分 １ ２ ３ ４ ５ ６ | | | | | | | | | | | | | | | 有効期間 | | | | 年 月 日から  　　 年 月 日まで | | | | | | |  |
| 利用中のサービスの種類と内容等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護保険  サービス | | | | 要介護認定 | | | | | 有・無 | | | | | 要介護度 | | | | | 要支援（　）・要介護　１　２　３　４　５ | | | | | | | | | | | | | | | | | | | |  |
| 利用中のサービスの種類と内容等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 世帯区分 | | | | | □生活保護　□低所得　□一般 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 申請する支援の種類・内容 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ 移動支援事業 | | | | | | | | | | | | | 時間／月 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ 訪問入浴サービス事業 | | | | | | | | | | | | | 回／月 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ 地域活動支援センター事業 | | | | | | | | | | | | | 回／月 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ 日中一時支援事業 | | | | | | | | | | | | | 回／月 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 申請書提出者 | | | | □申請者本人　　□申請者本人以外（下の欄に記入） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ | | | |  | | | | | | | | | | | | | | | | | | | | 申請者  との関係 | | | | | | | |  | | | | | | | | |
| 氏名 | | | |  | | | | | | | | | | | | | | | | | |  | |
| 住所 | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 調　査　同　意　書  地域生活支援事業の支給決定に必要のある場合には、この申請に係る、世帯状況、所得・課税状況、生活保護受給状況、介護保険受給等の状況、その他必要な事項を長久手市が官公署、関係人に調査、報告を求めることに同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | 申請者氏名 | | | | | | | |  | | | | | | | | | | | | | | 印 | |