**介護保険要介護認定・要支援認定区分変更申請書**

申請年月日　令和　　　年　　　月　　　日

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| （あて先）松山市長 |  | 001 | 002 | 003 | 004 |
| 次のとおり申請します。 |  |  | | | |

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| 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 | | 明・大・昭　　　　年　　　　月　　　　日 | | | | | | | | | | | | | | |
| 氏　　　名 | |  | | | | | | | | | | |
| 性別 | | 男　・　女 | | | | | | | | | | | | | | |
| 住　　　所 | | 松山市  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 前回の要介護  認定の結果等 | | 要介護状態区分　　 １　　　２　　　３　　　４　　　５　　　 要支援認定区分　　 １　　　２ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 有効期間　　　令和　　　年　　　月　　　日　から　令和　　　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 | | 介護保険施設の名称等 | | | | | | | | | | | 期間　　　年　　　月 日～　　　年　　　月 日 | | | | | | | | | | | | | | | | |
| 医療機関等の名称等 | | | | | | | | | | | 期間　　　年　　　月 日～　　　年　　　月 日 | | | | | | | | | | | | | | | | |

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| 申　請　書　提　出　者 | ①代行事業者 | 該当に🗸 | | □指定居宅介護支援事業所 | □介護老人保健施設 | | | | □介護医療院 | |
| □地域包括支援センター | □指定介護老人福祉施設  　（地域密着型介護老人福祉施設） | | | |  | |
| 名称 | |  | | | | | | |
| 所在地 | | 電話番号 | | | | | | |
| ①以外 | 氏名  名称 | |  | | | 本人との関係 | | |  |
| 住所 | | 電話番号 | | | | | | |
|  | | | | | | | | | | |
| 該当に🗸  □主治医□指定医 | | | 医師氏名 |  | | 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 | | | | | | | | | | |
| 特定疾病名 | | | |  | | | | | | |

**介護サービス計画の作成等介護保険事業の適切な運営の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、松山市から地域包括支援センター、居宅介護支援事業者、地域密着型ｻｰﾋﾞｽ事業者、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。**

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| 松山市確認欄  20240401 | |
| 確認 | 入力 |
|  |  |

本　人　氏　名

代筆者氏名（続柄）　　　　　　　　　　　　　　　　　　（　　　　　　）

親族以外の代筆理由

**裏面もご記入ください**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者 番号  ０  ０  ０ | |  |  | |  |  | |  |  |  |  |  |  | 被保険者 氏名 |  | | | |
| →調査日時相談者  に  🗸を入れてください | □ | 本人 | | 電話番号 | | | （自宅） | | | | | | | （携帯） | | | | |
| □ | 担当ケアマネジャー | | 事業者名 | | |  | | | | | | | | | | | |
| 担当者  氏　名 | | |  | | | | | | | | | | 調査同席 | 有　　　・　　　無 |
| 電話番号 | | | （職場） | | | | | | | （携帯） | | | | |
| □ | 上　記　以　外 | | 氏　　名 | | |  | | | | | | | | | | | |
| 被保険者  との関係 | | | □家族（続柄：　　　　　　　　　　 ）  □その他（ 　　　　　　　　　　　 ） | | | | | | | | | 調査同席 | | 有　　　・　　　無 |
| 電話番号 | | | （自宅）  （職場） | | | | | | | （携帯） | | | | |
| 訪問調査先  住民票と違う場合 | | | | 入院・入所  施設名等 | | | （　　　　　　　　　　　　号室） | | | | | | | | | | | |
| 住　　所 | | | ※マンション等の方は、棟名・部屋番号までご記入ください。 | | | | | | | | | | | |
| （電話番号　　　　　　　　　　　　　　　　　　　　　　）　　（　　　　　　　　　　　　　　　　　　　　方） | | | | | | | | | | | |
| 同居人の状況  （該当に🗸を入れてください） | | | | | | | □ 無（独居）　　　□ 配偶者　　　□ 子ども（　　　　　　　）　　　□ その他（　　　　　　　） | | | | | | | | | | | |
| 介護サービス利用状況  （現在利用している在宅サービス該当に🗸を入れてください） | | | | | | | □ 訪問介護（ホームヘルプ） （　　　　　　　　　　　　　　　　　　 曜日）  □ 通所介護（デイサービス） （　　　　　　　　　　　　　　　　　 　曜日）  □ 短期入所生活介護（ショートステイ）（次回予定：　　月　　日～　月　　日）  □ 福祉用具の貸与  □ その他（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　 ） | | | | | | | | | | | |
| 備　　　考  （調査時に留意してほしいこと、通院等で都合の悪い曜日、入院中の方は退院予定日などを記入してください） | | | | | | |  | | | | | | | | | | | |
| ＊調査スケジュールの都合により、ご希望の日時に添えない場合もありますのでご了承ください。 | | | | | | | | | | | | | | | | | | |

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| 調査員記入欄 |

**※担当ケアマネジャーの情報は必ず記入してください。**

**訪問調査連絡票**

＊訪問調査の日時は、調査員から電話連絡のうえ、ご相談させていただきます。

＊本人・同席者等への調査日時の連絡は、調査日時相談者からお願いします。