|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | |  | | | | |  | | | |  | | | |  | | | | | | |  | | | |  | | | | | | | | |  | | | | | | | |  | | | | |
| 様式第１号（第３条関係） | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | |  | | | | | | | | |  | | | | | | | |  | | | | |
|  | | | | | 障害児通所給付費支給申請書兼 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | 利用者負担額減額・免除等申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 貝塚市長　様 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | |
| 次のとおり申請します。 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | 年 月 日 | | | | | | | | | | | | | | | |
| 申　請　者 | | | フリガナ | | | | | |  | | | | | | | | | | | | | 個人番号 | | | | |  |  | | | |  | |  | |  | | |  | |  | |  | |  | | |  |  |  |
| 氏名 | | | | | |  | | | | | | | | | | |  | | 生年月日 | | | | | 年 月 日 | | | | | | | | | | | | | | | | | | | | | | | |
| 居住地 | | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | | | |  | | | | | | | | | | | | | |
| フリガナ | | | | | | | | |  | | | | | | | | | | | | | 個人番号 | | | | |  |  | | | |  | |  | |  | | |  | |  | |  | |  | | |  |  |  |
| 支給申請に係る障害児氏名 | | | | | | | | |  | | | | | | | | | | | | | 生年月日 | | | | | 年 月 日 | | | | | | | | | | | | | | | | | | | | | | | |
| 続　柄 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 身体障害者  手帳番号 | | | | |  | | | | | | | 療育手帳  番号 | | | |  | | | | | | | | 精神障害者保健  福祉手帳番号 | | | | | |  | | | | | | | | | | | | 疾病名 | | | | |  | | | |
| 被保険者証の記号及び番号(※) | | | | | | | | | | | | |  | | | | | | | | | | 保険者名及び番号(※) | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| * 「被保険者証の記号及び番号」欄及び「保険者名及び番号」欄は、肢体不自由児通所医療を申請する場合記入すること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| サービス利用の状況 | | 障害福祉  関係サービス | | | | | | 利用中のサービスの種類と内容等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申　請　す　る　支　援 | | 支援の種類 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 申請に係る具体的内容 | | | | | | | | | | | | | | | | | |
| □ | | 児童発達支援 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| □ | | 医療型児童発達支援 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | | 放課後等デイサービス | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | | 居宅訪問型児童発達支援 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | | 保育所等訪問支援 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 障害児支援利用計画を作成するために必要があるときは、通所支援の利用に関する意向聴取の内容及び医師意見書の全部又は一部を、貝塚市から指定障害児相談支援事業者、通所支援事業者又は障害児入所施設の関係人に提示することに同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | 申請者氏名 | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
|  |  | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 主治医 | 主治医の氏名 | | | | |  | 医療機関名 | | |  | | | | |
| 所　在　地 | | | | | 〒 | | | | | | | | |
|  | | | | | | | | |
|  | | | | 電話番号 | | | | |
|  | | | | | | | | | | | | | | |
| 申請する減免の種類 | □ | Ⅰ | 負担上限月額に関する認定 | | | | | | | | | | |  |
|  |  | 次の区分の適用を申請します。 | | | | | | | | | | |  |
|  | （あてはまるものに○をつける。いずれにも当てはまらない場合は空欄とすること。） | | | | | | | | | | |  |
| １．生活保護受給世帯 | | | | | | | | | | | | |
| ２．市町村民税非課税世帯に属する者 | | | | | | | | | | | | |
| ３．市町村民税課税世帯(所得割28万円未満)に属する者 | | | | | | | | | | | | |
| □ | Ⅱ | | 多子軽減措置に関する認定 | | | | | | | | | |  |
|  |  | | 次の区分の適用を申請します。 | | | | | | | | | |  |
|  | | （あてはまるものに○をつける。） | | | | | | | | | |  |
| １．第２子に該当する者 | | | | | | | | | | | | |
| ２．第３子以降に該当する者 | | | | | | | | | | | | |
| ※　在園証明等が必要となります。 | | | | | | | | | | | | |
| □ | Ⅲ | 生活保護への移行予防措置(自己負担減免措置、補足給付の特例措置）に関する認定 | | | | | | | | | | |  |
|  |  | 生活保護への移行予防措置(□自己負担減免措置　□補足給付の特例措置)を申請します。 | | | | | | | | | | | |
| ※　福祉事務所が発行する境界層対象者証明書が必要となります。 | | | | | | | | | | | |  |
| いずれも、事実関係を確認できる書類を添付して申請すること。 | | | | | | | | | | | | | | |
| 申請書提出者 | | | | | □申請者本人　　□申請者本人以外（下の欄に記入） | | | | | | | | | |
| 氏名 | | | | |  | | |  | | | 申請者との関係 | |  | |
| 住所 | | | | | 〒 | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | 電話番号 | | |  | | |
| 私は、利用者負担の減額・免除等を決定するために必要な場合、貝塚市長が私及び私と同一世帯にある者の課税台帳等を閲覧することに同意します。  氏名 | | | | | | | | | | | | | | |