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|  | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| 佐々町長　殿 | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |
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| 次のとおり申請します。 | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
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|  | | | | | | | | | | |  | | | | | | | | | | 申請年月日 | | | | | | | | | | | | | 年 月 日 | | | | | | | |
| 申　請　者 | | | フリガナ | | | | | |  | | | | | | | | | | | | | 生年月日 | | | | | 年 月 日 | | | | | | | | | | | | | | |
| 氏名 | | | | | | 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 | | | | |  | | | | | | | 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「保険者名及び保険者番号」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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | | 保育所等訪問支援 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 障害児支援利用計画又は通所支援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、佐々町から指定障害児相談支援事業者、通所支援事業者若しく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。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 申請者氏名 | | | | | |  | | | | | | | | | | | | 印 | | | | | | | | | | | | | | | | | |  | | | | |
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| 主治医（※） | 主治医の氏名 | | | | |  | 医療機関名 | | |  | | | | |
| 所　在　地 | | | | | 〒 | | | | | | | | |
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|  | | | | 電話番号 | | | | |
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| 申請する減免の種類 | □ | Ⅰ | 負担上限月額に関する認定 | | | | | | | | | | |  |
|  |  | 下記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 | | | | | | | | | |  |
|  |  | | 下記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 | |  | |
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