（様式１）

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| 軽度者福祉用具貸与例外給付の申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 申請日　　　　　年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 中間市保健福祉部介護保険課　宛 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 次の被保険者について、例外給付の対象となる福祉用具の貸与が必要となりましたので確認を依頼します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被　保　険　者 | 被保険者番号 | | | |  | |  | |  | | | | | |  | | | | |  | | |  | | | | | | |  | | | | | | |  | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | | | |
| フリガナ | | | |  | | | | | | | | | | | | | | | | | | | | | | 介護度 | | | | | | | | | | | | □ | | | | | | | 要支援 | | | | | | | | | | | □ | | | 要支援２ | | | | | | | □ | 要介護１ |
| 被保険者氏名 | | | |  | | | | | | | | | | | | | | | | | | | | | | □ | | | | | | | 要介護２ | | | | | | | | | | | □ | | | 要介護３ | | | | | | | □ | 申請中 |
| 住　所 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 認定の有効期間 | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | ～ | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
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| 申　請　者 | 申請者事業所番号 | | | |  | |  | | |  | | | | | |  | | | | |  | | | | |  | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | |  | | | |  | | | | | | | | | | |
| 申請者名  (居宅介護支援事業所)  (地域包括支援センター)  (介護予防支援事業所) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 地域包括支援センター委託先居宅介護支援事業所名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 地域包括支援センター  確認サイン | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 担当ケアマネジャー氏名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 担当ケアマネジャー連絡先 | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| メールアドレス | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
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| 貸与予定の福祉用具 | 貸与開始日(予定日) | | | | 年　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 例外給付の申請内容 | | | | □ | | | 新規 | | | | | □ | | | | 継続 | | | | | | | | □ | | | | | | 追加 | | | | | | | | | | | | | | | | □ | | | | | その他 | | | | | | （　　　　　　　　　　　　） | | | | | | | | | | |
| 福祉用具の種類 | | | | □ | | | 特殊寝台 | | | | | | | | | | | | | □ | | | | | | | 特殊寝台付属品 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ | | | | | | 床ずれ防止用具 | | | | |
| □ | | | 体位変換器 | | | | | | | | | | | | | □ | | | | | | | 移動用リフト（昇降座椅子） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | □ | | | | | | 認知症老人徘徊感知機器 | | | | |
| □ | | | 自動排泄処理装置（要介護２・３も含む） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 福祉用具貸与事業所 | | | | 事業所番号 | | | | | | |  | | | | | |  | | | |  | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | |  | | | | | |  | | |  | | | | |  | |  | | |
| 事業所名 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 医　学　的　所　見 | 医療機関名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医師名 | | | | | | | | | | | |  | | | | | |
| 傷病名等 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受診状況 | | | | 最終受診日 | | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 入院中(退院予定日) | | | | | | | | | | | | | | | | | | | | 年 　月　　日 | | | | | | |
| □ | (Ⅰ) | 疾病その他の原因により、状態が変動しやすく、日によって又は時間帯によって、頻繁に、「申請が行われる福祉用具が必要な状態」に該当する者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | (Ⅱ) | 疾病その他の原因により、状態が急激に悪化し、短期間のうちに「申請が行われる福祉用具が必要な状態に該当するに至る」ことが確実に認められる者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ | (Ⅲ) | 疾病その他の原因により、身体への重大な危険性又は症状の重篤化の回避等医学的判断から「申請が行われる福祉用具が必要な状態」に該当すると判断できる者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **保険者確認欄** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 上記の申請による被保険者に対して、軽度者福祉用具貸与の例外給付の対象とすることについて、次のとおり確認しました。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 中間市受付印 | | | |
| 確認日 | | | |  | |  | | | | | 年 | | | | | | | |  | | | | | | 月 | | | | | | | | | |  | | | | | | | | | | 日 | | | | | | | |  | | | | | | | | | | | |  | | | |
| 例外給付の適用開始日 | | | |  | |  | | | | | 年 | | | | | | | |  | | | | | | 月 | | | | | | | | | |  | | | | | | | | | | 日 | | | | | | | | より | | | | | | | | | | | |
| **例外給付の確認結果** | | | | □ | | **可** | | | | | **・** | | | | | | | | □ | | | | | **否** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 備考 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |