様式第１３号(第１９条関係)

**介護予防サービス計画作成依頼（変更）届出書（介護予防小規模多機能型居宅介護）**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者氏名 | | | | | | | | | | | | | | | | | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ | |  | | | | | | | | | | | | | | | | | | | |  | | |  | | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | 個人番号 | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 生年月日 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護予防サービス計画の作成を依頼（変更）する介護予防小規模多機能型居宅介護事業者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 事業所名 | | | | | | | | | | | | | | | | | | | 事業所の所在地 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 電話番号 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| 事業所番号 | | | | | | | | | | | | | | | | | | | サービス開始（変更・終了）年月日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | |  | |  |  |  | | |  | |  | | |  | | 新規・変更・終了 | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | | | | | |
| 事業所を変更する場合の理由等 | | | | | | | | | | | | | | | | | | | | ※変更する場合のみ記入してください | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 介護予防小規模多機能型居宅介護等の利用開始月における居宅サービス等の利用有無 | | | | | | | | | | | ※介護予防小規模多機能型居宅介護の利用前の介護予防サービス（介護予防居宅療養管理指導及び介護予防特定施設入居者生活介護を除く。）及び地域密着型サービス（介護予防認知症対応型通所介護及び介護予防認知症対応型共同生活介護（短期利用型）に限る。）の利用の有無を記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □介護予防サービス等の利用あり（利用したサービス：　　　　　　　　　　　　　　　　　　　　）  □介護予防サービス等の利用なし | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 肝付町長　　様  上記の介護予防小規模多機能型居宅介護事業者に介護予防サービス計画の作成を依頼することを届け出ます。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年　　月　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者 | | | | | | | | | | | 住所 | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 電話番号 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （注意） | | | | １　この届出書は，要支援認定の申請時に，若しくは介護予防サービス計画の作成をする事業所が決まり次第，速やかに肝付町へ提出してください。  ２　介護予防サービス計画の作成を依頼する事業所を変更するときは，変更年月日を記入の上，必ず肝付町に届け出てください。届出のない場合，サービスに係わる費用を一旦，全額自己負担していただくことがあります。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者確認欄 | | | | | | □ | | 被保険者資格 | | | | | | | | | | | | | | | | | | | □ | | | | 届出の重複 | | | | | | | | | | | | | | | | |
| □ | | 介護予防小規模多機能型居宅介護事業者事業所番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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