**介護予防サービス計画作成依頼（変更）届出書**

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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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 明・大・昭　　　年　　　月　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護予防サービス計画の作成を依頼(変更)する介護予防支援事業者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護予防支援事業者名 | | | | | | | | | | | | | | | | | 所在地 | | | | | | | | | | | | | | | | | | | | | | | | | | 〒 | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護予防支援事業者事業所番号 | | | | | | | | | | | | | | | | |  | | | | | |  | | | |  | | |  | | | | | |  | | | |  | | | |  | | | | |  | | |  | | |  | |
| 介護予防支援事業者若しくは地域包括支援センター又は、居宅介護支援事業者を変更する場合の事由等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ※　変更する場合のみ記入してください。  　　　　　　　変更年月日(　　　年　　月　　日付) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 浅　　口　　市　　長　　　　様 　上記の介護予防支援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出します。また、介護予防サービス計画の作成を依頼(変更)する介護予防支援事業者が介護予防支援の提供にあたり、被保険者の状況を把握する必要があるときは、要介護認定・要支援認定に係る調査内容、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当該介護予防支援事業者に必要な範囲で提示することに同意します。  　　　　　　　　年　　　月　　　日  　被保険者　住　所　　　　　　　　　　　　　　　　　　電話番号　　　(　　　)  　　　　　　本人氏名(自署)　　　　　　　　　　　　　　代筆者氏名　　　　 (続柄)  　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　(　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 保険者確認欄 | | |  | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | 被保険者資格 | | | | | | |  | | | | 届出の重複 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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(注　意)

　この届出書は、介護予防サービス計画の作成を依頼する事業所が決まり次第速やかに浅口市へ提出してください。届出のない場合、サービスに係る費用を一旦、全額自己負担していただくことがあります。