別記様式第38号(第20条関係)　　　　　　　　　　　　高額介護合算療養費等支給申請書兼自己負担額証明書交付申請書

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 申請対象年度 | | | | 年度 | | | 申請区分 | | | | 1　新規 | | | | | 2　変更 | | | 3　取下げ | |  | | | | | | | | | | | | | | | 支給申請書整理番号 | | | | | | | | |  | | | | | | | | | | | | | | | | |
| フリガナ | | |  | | | | | | | | | | | | | 生年月日 | | 年　　　月　　　日生 | | | | | | | | | | | 性別 | |  | | | 個人番号 | | | | | | | | |  |  | | |  |  |  | |  | |  | |  |  | |  | |  |  |
| 氏名 | | |  | | | | | | | | | | | | | 計算期間の始期及び終期 | | | | | | | | | 年月日 ～ 　年月日 | | | | | | | | | | | | | | | | | | |
| **◆ 国民健康保険資格情報** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者証記号 | | | | | | | | 被保険者証番号 | | | | | | | | | 続柄 | | | | | | | 保険者名称 | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | | | | 1 | 世帯主 | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 2 | 擬制世帯主 | | | | | |
| 3 | 世帯員 | | | | | |
| **◆ 後期高齢者医療資格情報** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | |
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| **◆ 介護保険資格情報** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険者番号 | | | | | | 被保険者番号 | | | | | | | | | | | | | | | | | 保険者名称 | | | | | | | | | | | | | | | | | | 加入期間 | | | | | | | | | | | | | | | | | | | | |
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| □　下記口座への振込を希望します。※下記口座情報記載必要 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □　給付金等の受取口座として国に登録した「公金受取口座」への振込を希望します。※下記口座情報記載不要（マイナポータル等による事前登録が必要です。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口座管理番号 | | 振込口座  記入欄 | | | 銀行  信用金庫  信用組合  協同組合  （） | | | | | 金融機関コード | | | | | | |  | | | 本店  支店  出張所 | | | | 店舗コード | | | 種目 | | | | 口座番号 | | | | | | | | | | | フリガナ | | | |  | | | | | | | | | | | | | 振込先口座 管理番号 | | |
|  | |  | |  |  | |  | |  |  |  | 1　普　通 | | | |  |  | | |  |  | |  |  |  | | 口座名義人 | | | |  | | | | | | | | | | | | |
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| ※ 上記 計算期間中（　年　月　日～　年　月　日）、市町村から重度心身障がい者医療費助成を受けていました。（　 は　い　　／　　 いいえ　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 保険者名 | | | | | | | 加入期間 | | | | | | | | | | | | | 添付の自己負担額証明書整理番号 | | | | | | | | | | | | | | | 市町村欄 | | | | 個人番号確認 | | | | | □個人番号カード | | | | | | □通知カード | | | | | □その他 | | | | |
| 保険者  加入歴 | 1 |  | | | | | | | 年　　　　月　　　　日から  年　　　　月　　　　日まで | | | | | | | | | | | | |  | | | | | | | | | | | | | | | 本人確認 | | | | | □個人番号カード | | | | | | □運転免許証 | | | | | □その他 | | | | |
| 代理権の確認 | | | | | □被保険者証 | | | | | | □委任状 | | | | | □その他 | | | | |
| 2 |  | | | | | | | 年　　　　月　　　　日から  年　　　　月　　　　日まで | | | | | | | | | | | | |  | | | | | | | | | | | | | | | 備考欄 | | | |  | | | | | | | | | | | | | | | | | | | | |
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| 福島県後期高齢者医療広域連合長  （市町村）長 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ①　上記対象者について、高額介護合算療養費(高額医療合算介護(予防)サービス費)の支給を申請します。  ②　上記対象者について、自己負担額証明書の交付を申請します。  なお、支給金は私（申請者）の上記口座に振込してください。口座名義人が私（申請者）と異なる場合は口座名義人を受領人と定め、本申請に係る支給金の受領を委任します。  また、支給後、自己負担額の異動等により給付費が減額となった場合は、その差額を返還することに同意します。  ※自己負担額証明書の交付申請を行う場合、①・②のいずれも丸で囲んで下さい。  　高額介護合算療養費(高額医療合算介護(予防)サービス費)の支給申請を行う場合、①のみを丸で囲んで下さい。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 住所 | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申請者  氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 電話番号 | | | | | －　　　　　　－ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | 広域連合欄 | 受付 | 入力 | 照合 | |  |  |  |   氏名  住所  □本人  □代理人（続柄：　　）  提出者等  電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **枚中** | |  | | | | **枚目** | |