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| **様式第１号（第４条関係）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **伊達市** | | | | | | | |
| 育成医療費支給認定申請書（新規・再認定・変更・転入）　※１ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受診児 | フリガナ | |  | | | | | | | | 性別 | | | | | 男・女 | | | | 年齢 | | | | | | | 歳 | | | | | | 生　年　月　日 | | | | | | | | | | | | | |
| 受診児氏名 | |  | | | | | | | |  | | | | | 年　　　月　　　日 | | | | | | | | |
| フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | 電話番号 | | | | | |  | | | | | | | | | | | | | |
| 郵便番号　　　　　　　　　受診児住所 | | 〒　　　　－ | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | |  |  |  | | |  | |  | | | |  | | |  | | | | |  | | | | | | |  | | | | |  | | | | | | |  | |  | | | |
| 保護者 | フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | 受診児  との関係 | | | | | |  | | | | | | | | | | | | | |
| 保護者氏名 | |  | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | 電話番号  ※２ | | | | | |  | | | | | | | | | | | | | |
| 保護者住所 ※２ | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | |  |  |  | | |  | | |  | | | |  | | |  | | | | |  | | | | | | |  | | | | |  | | | | | | |  | |  | | |
| 負担額に関する事項 | 受診児の被保険者証の記号及び番号 | |  | | | | | | | | | | | | | 保険者名 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受診児と同一保険の加入者 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | |  |  |  | | |  | | |  | | | |  | | |  | | | | | |  | | | | | | |  | | | | |  | | | | | |  | |  | | |
| 重度かつ継続※３ | | 該当　・　非該当 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受診を希望する指定自立支援医療機関（薬局・訪問看護事業者を含む） | | | 医　療　機　関　名 | | | | | | | | | | | | | | | | | 所 在 地・ 電 話 番 号 | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受給者番号　※４ | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 私は、上記のとおり、自立支援医療費（育成医療）の支給を申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 自立支援医療費（育成医療）支給申請の支給決定のため、私の世帯の住民登録資料、税務資料について、各関係機関に調査、照会、閲覧することを承諾します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 申請者氏名 |  | | | | | | | 印 | | | | ※５ | | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | | | | | | |
|  |  | 年　　　月　　　日 | | | | | | |  | | | |  | | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | | | | | | |
|  |  | 伊　達　市　長 | | | | |  | |  | | | |  | | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | | | | | | |
| ※１　該当する医療の新規・再認定・変更（自己負担限度額及び指定医療機関の変更認定の申請の場合）・転入のいずれかに○をする。  ※２　受診児本人と異なる場合に記入。  ※３　チェックシートを参照し、該当すると思う区分に○をする。  ※４　再認定または変更の方のみ記入。  ※５　申請者氏名については、記名押印又は自筆による署名のいずれかとすること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  | ここから下の欄には記入しないでください | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| 自治体記入欄 | |  | | | | |  | |  | | | |  | | | | | |  | |  | | | | | | | | | | |  | | | | | | | | | | | | |
| 申請受付年月日 | |  | | | | 判定依頼年月日 | | | | | |  | | | | | | | | | | | | | 認定年月日 | | | | | | | | | | | | | | |  | | | | | | |
| 今回所得区分 | | 生保　・　低１　・　低２　・　中間１　・　中間２　・　一定以上 | | | | | | | | | | | | | | | | | | | | | | | | | | 重度かつ継続 | | | | | | | | | | | 該当　・　非該当 | | | | | | |
| 所得確認書類 | | 個人番号　　　市町村民税課税証明書　　　　市町村民税非課税証明書　　　　　標準負担額減額認定証 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 生活保護受給世帯の証明書　　　その他収入等を証明する書類（　　　　　　　　　　　　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 備　考 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |