サービス提供証明書

（介護予防・日常生活支援総合事業費（訪問型サービス費・通所型サービス費・その他の生活支援サービス費））

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| 公費負担者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 平成 |  |  | 年 |  |  | 月分 |
| 公費受給者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者 | 被保険者番号 |  |  |  |  |  |  |  |  |  |  |  | 請求事業者 | 事業所番号 |  |  |  |  |  |  |  |  |  |  |
| (ﾌﾘｶﾞﾅ)氏名 |  | 事業所名称 |  |
|  |
| 所在地 | 〒 |  |  |  | － |  |  |  |  |  |
| 生年月日 | 1.明治　2.大正　3.昭和 | 性別 | 1．男　2．女 |  |
|  |  | 年 |  |  | 月 |  |  | 日 |
| 要支援状態区分等 | 事業対象者・要支援１・要支援２ |
| 認定有効期間 | 平成 |  |  | 年 |  |  | 月 |  |  | 日 | から | 連絡先 | 電話番号 |
| 平成 |  |  | 年 |  |  | 月 |  |  | 日 | まで |

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| 介護予防サービス計画 | ３．介護予防支援事業者・地域包括支援センター作成 |
| 事業所番号 |  |  |  |  |  |  |  |  |  |  | 事業所名称 |  |

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| 開始年月日 | 平成 |  |  | 年 |  |  | 月 |  |  | 日 | 中止年月日 | 平成 |  |  | 年 |  |  | 月 |  |  | 日 |

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| 事業費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 摘要 |
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| (住所地特例対象者) 事業費明細欄 | サービス内容 | サービスコード | 単位数 | 回数 | サービス単位数 | 公費分回数 | 公費対象単位数 | 施設所在保険者番号 | 摘要 |
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| 請求額集計欄 | ①サービス種類コード／②名称 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ③サービス実日数 |  |  | 日 |  |  | 日 |  |  | 日 |  |  | 日 |
| ④計画単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤限度額管理対象単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑥限度額管理対象外単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 給付率（/100） |
| ⑦給付単位数（④⑤のうち少ない数）＋⑥ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 事業 |  |  |  |
| ⑧公費分単位数 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 公費 |  |  |  |
| ⑨単位数単価 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 |  |  |  |  | 円／単位 | 合計 |
| ⑩事業費請求額 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑪利用者負担額 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑫公費請求額 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑬公費分本人負担 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|  | 枚中 |  | 枚目 |