様式第12号（第20条関係）　Form 12 (Article 20)

Application Form for Medical Support for Self-reliance

(Child with disability/ Person with disability) (New/ Reapproval/ Change) *1

Patient	Katakana	カナザワ　ハルコ	Date of birth	
	Name	**Kanazawa Haruko**	◇◇(Year)　◇◇(Month)　◇◇(Day)	
	Address	**1-1-1 Hirosaka, Kanazawa**	Tel	076−123−4567
	Individual Number	**123456789012**		
When the patient is a minor	Katakana		Relation to the patient	
	Guardian's name			
	Guardian's address *2		Tel	
	Guardian's Individual Number			

Write the medical insurance certificate code/No.

Write the insurer's name and number of the health insurance certificate.

Items related to self-pay amounts	Patient's health insurance certificate code/No.	**123**	**4567**	Insurer's name	**Kanazawa City**	Insurer's No.	**170027**
	Insured person's name			Relation to the patient		Address	**1-1-1 Hirosaka, Kanazawa**

Persons covered by the same insurance	Name	Individual Number	Name	Individual Number
	Kanazawa Ichiro	**741852963074**		
	Taro	**963852741096**		

Write the names and Individual Numbers of all persons covered by the same insurance as the patient.

Income category *3	Welfare・Low 1・Low 2・Middle 1・Middle 2・Higher than the standard	Severe and ongoing *3	Yes　•　No
Physical disability certificate *4	Ishikawa Prefecture　•　Kanazawa City　　Grade:		

Write the physical disability certificate grade, etc.

Medical institutions specified for medical support for the disabled (including pharmacies and home-visit nursing services)	Medical institution's name	Address/ Tel
	○○○ **Hospital**	○−○−○ **Sainen, Kanazawa**
	△△△ **Pharmacy**	△−△−△ **Sainen, Kanazawa**

Write the names of the medical institutions you visit and the pharmacies you go to for prescriptions. Write all the institutions you use.

I hereby apply for medical support for self-reliance.

Applicant's name　**Kanazawa Haruko**

◇◇ (Year)　◇ (Month)　◇ (Day)

（Addressee）　Manager, Kanazawa City Social Welfare Office

*1: Circle the appropriate category (Child with disability or Person with disability) and application type (New, Reapproval or Change (change of self-pay maximum or medical institutions)).
*2: Write the address if it is different from the patient's address.
*3: Refer to the check sheet and circle the appropriate category.
*4: If you have a physical disability certificate, write the details.

Do not fill in the items below.

自治体記入欄

申請受付年月日	駅西 ・ 元町 ・ 泉野 ・ 本庁	認定年月日	
前回所得区分	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
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	市民税課税・非課税証明書　市民税通知書　標準負担額減額認定証　生活保護受給世帯の証明書 税端末　その他収入等を証明する書類（　）		
変更の場合変更日	年　月　日	今回の受給者番号	
非課税収入	有（８０万円超・８０万円以下）・無	特定疾病療養受療証	有 ・ 無

確認					備考
	番号	個人　通知　住民　端末（　）	代理	法定　戸籍　本人　委任	
	本人	個人　免許　手帳　在留　旅券　住基B　保険　介護　年金　その他（　）			