**様式第二の二**（附則第二条関係）

サービス提供証明書

（介護予防訪問介護・介護予防訪問入浴介護・介護予防訪問看護・介護予防訪問リハ・介護予防居宅療養管理指導・介護予防通所介護・介護予防通所リハ・介護予防福祉用具貸与・介護予防認知症対応型通所介護・介護予防小規模多機能型居宅介護（短期利用以外）・介護予防小規模多機能型居宅介護（短期利用））

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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 |  | | | | | | | | | | | | | | | | | |
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| 生年月日 | 1.明治　2.大正　3.昭和 | | | | | | | | | | | | | | | | | 性別 | | | 1．男　2．女 | | | | | | |  | | | | | | | | | | | | | | | | | |
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| 要支援  状態区分 | 要支援1・要支援2 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 認定有効  期間 |  | |  | | |  | | | 年 | | |  | | |  | | | 月 | |  | | |  | | 日 | | から | 連絡先 | 電話番号 | | | | | | | | | | | | | | | | | |
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| 介護予防  サービス  計画 | ２．被保険者自己作成　　　　　３．介護予防支援事業者作成 | | | | | | | | | | | | |
| 事業所  番号 |  |  |  |  |  |  |  |  |  |  | 事業所  名称 |  |

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| 中止  理由 | 1.非該当　3.医療機関入院　4.死亡　5.その他　6.介護老人福祉施設入所　7.介護老人保健施設入所　8.介護療養型医療施設入院  9.介護医療院入所 | | | | | | | | | | | | | | | | | | | | |

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| (住所地特例  対象者)  給付費明細欄 | 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 保険 | | |  |  |  |
| 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保険請求額 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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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| 社会福祉  法人等に  よる軽減  欄 | 軽減率 | |  |  |  |  | ％ | 受領すべき利用者  負担の総額（円） | | | | | | 軽減額（円） | | | | | | 軽減後利用者  負担額（円） | | | | | | 備考 |
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