

Long-Term Care Benefits, Training and Other Benefits, Special Benefits for Persons with Specific Disabilities, Community Consultation Support Benefits

Application for Benefits and Application for Reduction or Exemption of User-Paid Amounts

To Director of Komaki city Welfare

I hereby submit the following application. I consent to the investigation, inquiry, and review of my household tax records and public assistance receipt status for the purpose of deciding on this application.

Application date Reiwa year 8 month 4 day 1

Applicant	Furigana	コマキ タロウ		My Number	1	1	1	1	1	1	1	1	1	1	1	1	1
	Name	KOMAKI TAROU		Date of Birth	Taisho <u>26</u> Showa <u>33</u> Heisei <u>33</u> Reiwa <u>1</u> Year <u>33</u> month <u>1</u> day <u>1</u>												
	Address	〒485-8650 Komaki shi Horinouchi 3 choume 1 banchi Phone number 0568-76-1127															
	Furigana			My Number													
	Name of the child who apply for the benefit			Date of Birth	Heisei Reiwa year __ month __ day												
				Relation													
	Physical disability booklet number		Intellectual disability booklet number		Mental disability Health and welfare booklet number				Name of the disease								
Applicant receives a Grade 1 Basic Disability Pension (limited to applicants for continued employment support services)																	
Yes - No																	

Situation of use of the	Welfare Services for disabled persons	Disability Support Certification of Disability Category	☒ Yes ☐ No	Category	1	2	3	4	5	6	Validity Period	Reiwa 6 year 1 month 1 day ~ Reiwa 8 year 12 month 31 day			
		Types and Details of Services Currently in Use, etc.													
	Long-Term Care Insurance Services	Certification of Need for Long-Term Care	☒ Yes ☐ No	Grade of care	1	2	3	4	5	Needing Support	1	2	3	4	5
	Type of actual use of service and contents														

Applied Services	Category	Type of Detailed Service		Contents Detailed Description
		Care Benefits	Training and Other Benefits	
	At home services	☒ At home assistance	☐ Support for work stability	Home assistance (personal care) 5 hours/month
		☐ At home intensive Assistance	☐ Support for an independent life	
		☐ Accompaniment Support	☐ Support for job selection	
		☐ Behavioral Support		
		☐ Integrated Support for Persons with Severe Disabilities,		
	Training Services and Job Support Day Activities Services	☐ Short time Hospitalization	☐ Training for autonomy (functional training)	
		☐ Medical Care Services	☐ Training for autonomy (daily life training)	
		☐ Daily life Assistance Services	☐ Stay-and-Train Program	
		☐ Support for job transition		
		☐ Employment Preparation Support (Training Facility)		
		☐ Type A Continuous Job Support		
		☐ Type B Continuous Job Support		
Residential	☐ Support for living in facilities	☐ Life in group Support (Group home)		
Support for consulting in the community	☐ Support for Transition to the			
	☐ Support for Settling in the			

If necessary for the preparation of a Service Use Plan or Individual Support Plan, I agree that Komaki City may disclose all or part of the following information to relevant personnel at designated specific consultation support providers, designated disability welfare service providers, designated disability support facilities, or designated general consultation support providers: the contents of the certification survey and general assessment related to the certification of disability support categories; the results of the consultation regarding service utilization preferences; the review results and opinions of the municipal review committee; and the doctor's recommendation letter.

Name of Applicant **Komaki Tarou**

Doctor in charge	Name of the doctor in charge		Name of the facility	
	Address	Phone number		

(※) The attending doctor should be filled out when applying for long-term care benefits, training and other benefits (limited to cases related to shared living support where the person wishes to receive assistance with bathing, toileting, or meals, and when they wish to use a daytime service support-type designated shared living facility), or community transition support (limited to those hospitalized in psychiatric hospitals, including hospital wards for psychiatric patients in non-psychiatric hospitals).

Application for Types of Reduction/Exemption	☐ I Certification regarding the monthly maximum burden I am applying for the application of the following category. (Please ○ the applicable item. Leave blank if none apply.) 1. Households receiving welfare assistance 2. Households who belong to households exempt from municipal resident tax (※) ※ When using medical care services, also mark ○ for those who meet ① or ②: ① Those whose total income and income from disability basic pensions, etc., is 809,000 yen or less ② Persons other than ① 3. People belonging to households paying municipal tax (for people with disabilities: income portion under 160,000 yen, for children with disabilities or facility residents under 20 years: income portion under 280,000 yen)	
	☐ II Certification for Medical-Type Individual Exemption Since any of the following applications, I am applying for a medical-type individual exemption.	
	< Those who are 20 years old or older > 1. Being a person who uses medical care services (age: ____ years) 2. Households exempted of municipal tax	< Those who are under 20 years old > 1. Being a person who uses medical care services (age: ____ years)
	☐ III Certification for Special Benefits for Specified Persons with Disabilities (Supplementary Benefits) for Facilities Residents (Measures to Reduce Meal Costs in Residential Facilities) Since all of the following applications, I will apply for the special benefits for specified people with disabilities. (Note) The facilities in question are residential facilities (support facilities for people with disabilities) eligible for long-term care benefits.	
	< Those who are 20 years old or older > 1. Being a resident of a facility age: ____ years 2. Households exempted of municipal tax or welfare beneficiary	< Those who are under 20 years old > 1. Being a resident of a facility age: ____ years
	☐ IV Certification for Special Benefits for Specific Disabled Persons (Supplementary Benefits) for Residents of Group Homes (Rent Reduction Measures) Since the household falls under either non-taxable municipal resident tax households or welfare recipient households, we will apply for the special benefits for specific disabled persons. a.	
☐ V ☐ Certification Regarding Preventive Measures for Transitioning to Public Assistance (Self-Payment Reduction Measures, Special Measures for Supplemental Benefits) I am applying for preventive measures for transitioning to public assistance (☐ Self-Payment Reduction Measures ☐ Special Measures for Supplemental Benefits). ※ A certificate for low income recipients issued by the welfare office is required.		

In all cases, please submit your application along with documents that verify the facts

Applicant	☒ Applicant ☐ Other person than applicant (fill the space below)		
Name		Relation with the applicant	
Address	Phone number		