

Application for Community Living Support Program

(To) Komaki City Welfare Director

I hereby apply for participation in the Community Living Support Program as described below.

I also consent to the review of tax-related documents, such as tax assessment records, pertaining to myself and my household for the purpose of determining approval of this application.

Application date: year 8 month 4 day 1

Applicant	Furigana	コマキ ハナコ		Date of Birth	Taisho Showa Heisei Reiwa	
	Name	Komaki Hanako			Year <u>33</u> month <u>1</u> day <u>1</u>	
	Address	〒		Phone number		
Furigana				Date of Birth	year__month__day__	
Name of the child		My Number :		Relation		
Physical Disabled booklet number			Intellectual Disabled booklet number	22222 Chuo Jidou A Chuudo	Mental Disabled Health and Welfare booklet number	
Name of the disease						

Service in use Situation	Welfare related Services for disabled persons .	Certification of Disa	No	Validity period	
	Type and contents of the actual service in use				
	Long Term care Insurance	Confirmation of Needed Support	Yes No	Grade of required Assistance	Needed Support (2) / Needing Care: 1, 2, 3, 4, 5
Type and contents of actual services in use					
Type and contents Applied Assistance	Type of Service			Application Specific Contents	
	☐ Community Activities Assistance Center			Home assistance 2 hours/month	
	☒ Mobility Support Service				
	☐ Day Temporary Assistance Service				
	☐ Daily Life Assistance Service				

Please note that as long as business operators takes the disability into consideration and provides reasonable assistance, we will not hold to them or your city liable, including for legal liability in the event of any unexpected accidents, injuries, or similar incidents.

Name Komaki Hanako

Doctor in charge (※)	Name of the doctor in charge		Name of the medical facility	
	Address	Phone number		

(※) Fill in the “Attending Physician” section when applying for long-term care benefits, training and other benefits (limited to those related to group living support, and only if you wish to receive care for bathing, toileting, or meals), or community transition support (limited to individuals currently hospitalized in a psychiatric hospital, including hospitals other than psychiatric hospitals that have psychiatric wards).

Type of Reduction or exemption applied	☐ I Certification Regarding the Monthly Cost Cap Limit ☐ I am applying for the following category. ☐ (Mark a ○ to the applicable category. If none apply, leave this field blank.) 1. Households Receiving Welfare Assistance 2. Individuals belonging to households exempt from municipal resident tax (※) ※ If you are using medical care services, please mark Mark a ○ in the applicable option ☐ ① Persons whose total income, including the Basic Disability Pension and other sources, does not exceed 800,000 yen ☐ ② Persons other than those described in ① 3. Persons belonging to households subject to municipal resident tax (persons with disabilities: income-based tax of less than 160,000 yen; children with disabilities: income-based tax of less than 280,000 yen)
	☐ II Certification for Medical-Based Individual Fee Reduction ☐ Since I meet all of the following criteria, I am applying for a medical-based individual fee <Persons 20 years-old or older> 1. Be a recipient of long-term care services (Age: years old) 2. Belong of households exempt from municipal resident tax <Persons under 20 years-old> 1 Be a recipient of long-term care services (Age: years old)
	☐ III Certification for Special Benefits for Persons with Specific Disabilities (Supplementary Benefits) for Residents of Facilities (Note) (Measures to Reduce Meal Costs, etc., at Residential Facilities) ☐ Since I meet all of the following criteria, I am applying for Special Benefits for Persons with Specific Disabilities. ☐ (Note) Eligible facilities are residential facilities (facilities for persons with disabilities) that are eligible for long-term care benefits.
	<Persons 20 years-old or older> > 1. Be a resident of a facility (Age: years old) 2. Belong of households exempt from municipal resident tax or receiving welfare support <Persons under 20 years-old> 1.Be a resident of a facility (Age: years old)
	☐ IV Certification Regarding the Special Allowance for Persons with Specific Disabilities (Supplementary Allowance) for Group Home Residents (Rent Reduction Measure) ☐ Since we fall under the category of households exempt from municipal resident tax or households receiving public assistance, we are applying for the Special Allowance for Persons with Specific Disabilities.
	☐ V Certification Regarding Measures to Prevent Transition to Welfare Assistance (Measures to Reduce or Exempt Self-Payments, Special Measures for Supplemental Benefits) ☐ I am applying for measures to prevent transition to public assistance (☐ Measures to Reduce or Exempt Self-Payments, ☐ Special Measures for Supplemental Benefits). ☐ ※Certificate of Eligibility for Low Income issued by the Welfare is required.

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

Submission application of	☐ Applicant ☒ Other person than the applicant (fill the data below)		
Name	Komaki Tarou	Relation	Ko
Address	〒485-8650 Komaki shi Horinouchi 3 choume 1 banchi ☒ As written in the domicile register		
	Phone number 0568-76-1127		