

(Care Benefits for Children with Disabilities / Consultation Support Benefits for Children with Disabilities)
Application for Benefits, Application for Reduction or Exempt User Fees, and Request for Consultation Support for Children with Disabilities

(To) Komaki city Welfare

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

Date of application Reiwa year 8 month 4 day 1

Applicant	Furigana	コマキ タロウ		Date of Birth	Taisho Showa year 3 month 1 day 1		
	Name	Komaki Taro			Heisei Reiwa		
	Address	〒 485-8650 Komaki shi Horinouchi 3-1 Phone number 0568-76-1127					
Name of the Child who apply for the benefit	Furigana	コマキ ショウタロウ		Date of Birth	Heisei Reiwa year 5 month 1 day 1		
		Komaki Shoutarou		Relation	Ko		
Physical disabled booklet number		Intellectual disabled booklet number		Mental and Welfare booklet number		Name of the disease	

Service Situation of use	Welfare related Services for Disabled persons	Type and contents of the actual service use
Applied support	Support Type	Detailed description of the application (Write the details of use and desired starting date for each service) (in case of consultation /support for disabled children, write the name of the institution)
	☒ Support for the child development (except for children physical disabled treatment services)	Assistance for child development 23 days/month
	☐ Support service for the child development (limited for physical disabled children treatment services)	
	☐ After school services for disabled children	
	☐ Support service for pre-school, school or institutions visits	
	☒ Support service and orientation for disabled children	Consultation for disabled children Assistance and Counseling〇〇 Center

I consent to the Komaki City Welfare investigating, inquiring about, and reviewing public records and other documents regarding my household's tax records and public assistance receipt status for the purpose of making a decision regarding this application (notification). Furthermore, if necessary for the preparation of a Support Plan for Children with Disabilities or Day Service Support Plan, I consent to the Komaki City Welfare providing the contents of the consultation regarding my intentions for using day service support, as well as all or part of the doctor's opinion, to designated consultation support providers for children with disabilities, day service providers, or relevant personnel at residential facilities for children

Name of applicant Komaki Tarou

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

Type of Reduction or exemption Applied	☐ I. Certification Regarding the Monthly Cost Limit I am applying for the following option (Mark a ○ to the applicable option. If none apply, leave this field blank.) 1. Households receiving public welfare assistance 2. Individuals belonging to households exempted from municipal resident tax 3. Individuals belonging to households subject to municipal resident tax (with an income-based tax assessment of less than 280,000 yen)
	☐ II. Certification Regarding Measures to Ease the Burden on Families with Multiple Children I am applying for the following option (Mark a ○ to the applicable option. If none apply, leave this field blank.) (Mark a ○ to the applicable option. If none apply, leave this field blank.) 1. Persons having a 2nd child 2. Persons having 3rd or more children * Proof of day care enrollment, etc., is required.
	☐ III. Certification Regarding Measures to Prevent Transition to Public Assistance (Measures to Reduce or Exempt Self-Payments Expenses, Special Measures for Supplemental Benefits) I am applying for measures to prevent transition to public assistance (☐ Measures to Reduce or Exempt Self-Payments Expenses, ☐ Special Measures for Supplemental Benefits). * Certificate of Eligibility for the Low-Income Income Group 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		