第４号様式（第３条関係）

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| 特定医療費（指定難病）支給認定申請書  （　新規　・　変更　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 受給者番号 | | | | | | | | | | | | | | |  | |  | |  | |  | |
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| 受  診  者 | | フリガナ | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  | | | | 年齢 | | | | | 生年月日 | | | | | | | | | |
| 氏　　名 | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  | | | |  | | | | | 大 ・ 昭 ・ 平 ・ 令 | | | | | | | | | |
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| 住　　所 | | | | | | | 〒 | | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 電話番号 | | | | | | | | | | | | | | |
| 浜松市　　　　　　区 | | | | | | | | | | | | | | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 自宅　　　 － 　　　　　－  携帯　　　 － 　　　　　－ | | | | | | | | | | | | | | |
| 個人番号 | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | | | | | | | | | | |
| 加入医療保険 | | | | | | | 保険者名（称） | | | | | | | | | | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 保険種別 | | | | | | 国保（組合）・後期・  協会・組合・共済・  その他（　　　　　　） | | | | | | | | |
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| 記号・番号 | | | | | | | | | | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |
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| 被保険者氏名 | | | | | | | | | | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 受診者との続柄 | | | | | |  |  |  |  |  |  |  |  |  |
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| 申  請  者 | | フリガナ | | | | | | |  |  | | | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 受診者との続柄 | | | | | | | | | | | | | | |
| 氏名 | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | | | | | | | | | | | | | |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |
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| 住所 | | | | | | | 〒 | | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | | □受診者と同じ（記載省略可） | | | | | | | | | | | | | | 電話番号 | | | | | | | | | | | | | | |
|  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  | 自宅　　　 － 　　　　　－  携帯　　　 － 　　　　　－ | | | | | | | | | | | | | | |
| 個人番号 | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | | | | | | | | | | |
| 疾　　病　　名 | | | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |
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| 自己負担上限額の特例  （該当するものに☑） | | | | | | | | | □ | | | 軽症高額該当 | | | | | | | | | | | | | | | | | | □ | | | | 高額かつ長期  （高額難病治療継続者） | | | | | | | | | | | | | | □ | | 人工呼吸器等装着 | | | | | | | | | | | |
| 受診を希望する指定医療機関  （薬局、訪問看護事業者等を含む）  （該当するものに☑）  ※書ききれない場合は別紙に記入してください | | | | | | | | | № | 医療機関名（支店名等も記入） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 所　在　地 | | | | | | | | | | | | | | | | | | | 備考 | | |
| 1 | □病院・診療所　　　　　　　□薬局　　　　　　　□訪問看護 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | □追加  □削除 | | |
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| 2 | □病院・診療所　　　　　　　□薬局　　　　　　　□訪問看護 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | □追加  □削除 | | |
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| 3 | □病院・診療所　　　　　　　□薬局　　　　　　　□訪問看護 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | □追加  □削除 | | |
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| 特定医療費の支給を開始することが適当と考えられる年月日 | | | | | | | | | 年　　　月　　　日 | | | | | | | | | | | | | | | | 【左記の欄が申請日から1か月以上前の年月日となっている理由】  □臨床調査個人票の受領に時間を要したため  □症状の悪化等により、申請書類の準備や提出に時間を要したため  □大規模災害に被災したこと等により、申請書類の提出に時間を要したため  □その他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ＜同意について（情報確認）＞  この申請の審査に必要な場合は、浜松市において、臨床調査個人票に関する医療情報、市民税等に関する課税情報、　医療保険上の所得区分情報(国保組合を除く)、国民健康保険情報、後期高齢者医療情報、生活保護受給情報、特別児童　扶養手当情報、特別障害者手当情報、障害児福祉手当情報、小児慢性特定疾病情報を確認されることに同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （あて先）浜松市長 | | | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |
| 上記及び裏面のとおり、特定医療費の支給を申請します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 臨床調査個人票の研究等への利用についての同意をされる方は、「研究利用に関する御説明」を御確認いただき、以下に記名をお願いします。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （あて先）厚生労働大臣 | | | | | | | | | | | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |
| 私は、指定難病の医療費助成の申請に当たり提出した臨床調査個人票の情報が、①厚生労働省のデータベースに登録されること、②研究機関等の第三者に提供され、指定難病に関する創薬の研究開発等に利用されることに同意します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  |  |  |  |  |  |  |  |  | |  | | 申請者氏名 | | | | | | | | | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
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| ＜浜松市記入欄＞ | | | | | | | | |  |  | |  | |  | |  |  |  | |  | |  | |  |  |  | |  | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | **※裏面も御記入**  **ください** | | | | | | | | | |
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| ＜同意について（事業活用）＞ | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 本申請書及び添付資料等の内容について、浜松市の実施する次の難病対策事業に活用されることに同意します。  　　・難病をお持ちの方やその御家族に対する現状の施策向上や新規事業を検討するための資料とすること。  　　・浜松市が行う訪問相談や医療相談の御案内に利用すること。  　　・自然災害発生に備えて、支援が必要な方を事前に把握し、発災後の円滑な支援を行うための資料とすること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| １　受診者と同じ医療保険に加入する方を記入してください。  　また、指定難病・小児慢性特定疾病の受診者(申請中の者を含む)である場合は、受給者証等の写しを添付してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | 世帯員氏名 | | | | | | | | | | 受診者  との  続柄 | | | | 受給資格  （該当するものに○） | | | | | | | | | | １月１日現在の住所所在地 | | | | | | | | | | | | 個人番号 | | | | | | | | | | | |
| □ | | 世帯員全員が浜松市の場合に☑（以下記載省略可） | | | | | | | | | |
|  |
|  | 患者 | 受診者と同じ | | | | | | | | | | 本人 | | | | 指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  | | | | | | | | | | | |
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|  | 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 4 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 7 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 8 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | なし・指定難病・小児慢性 | | | | | | | | | |  |  |  | 都・道  府・県 | | |  |  |  | 市・区  町・村 | | |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | ※　１月１日現在の住所所在地について、１月から６月までに申請する場合は前年の１月１日在住の市区町村、７月から  12月までに申請する場合は当年の１月１日在住の市区町村を記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ２　受診者の生活保護受給について該当する方に○を付してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 生活保護受給の有無 | | | | | | | | | | | | | | | | | | 有　 ・ 　無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 上欄で有の場合、医療保険加入の有無 | | | | | | | | | | | | | | | | | | 有　 ・ 　無　 ※有の場合、表面の加入医療保険情報を記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ３　未申告等、課税状況が確認できない場合の負担上限月額最高階層の同意について | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 私は、負担上限月額が最高階層になることを了承します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 申請者氏名 | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |
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| ４　受診者（受診者が18歳未満の場合は、保護者の全て）の収入金額について記入し、収入が80万円以下の場合は、  振込通知書等収入金額がわかるものの写しを提出してください。なお、下の表に記入されているもの以外の収入については記入する必要がありません。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 氏　名 | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 氏　名 | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 収入の区分 | | | | | | 種類（該当するものに○） | | | | | | | | | | | | 収入金額 | | | | | | | 収入の区分 | | | | | | 種類（該当するものに○） | | | | | | | | | | | | 収入金額 | | | | | |
|  | １　年金 | | | | | | 障害　・　遺族　・　寡婦 | | | | | | | | | | | |  |  |  |  |  | 円 | | １　年金 | | | | | | 障害　・　遺族　・　寡婦 | | | | | | | | | | | |  |  |  |  | 円 | |
|  | ２　手当金 | | | | | | 特別児童扶養 ・ 特別障害者 ・ 障害児福祉 | | | | | | | | | | | |  |  |  |  |  | 円 | | ２　手当金 | | | | | | 特別児童扶養 ・ 特別障害者 ・ 障害児福祉 | | | | | | | | | | | |  |  |  |  | 円 | |
|  | ３　その他 | | | | | | 障害一時金 ・ 障害給付金 ・ 障害補償 | | | | | | | | | | | |  |  |  |  |  | 円 | | ３　その他 | | | | | | 障害一時金 ・ 障害給付金 ・ 障害補償 | | | | | | | | | | | |  |  |  |  | 円 | |
|  | ※　記入する収入金額は、１月から６月までに申請する場合は前々年（１月から１２月まで）の収入金額、７月から１２月  までに申請する場合は前年（１月から１２月まで）の収入金額としてください。  ※　収入金額がない場合は、０円と記入してください。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ※書類別送先（希望者のみ記入） | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  | ※申請内容問合せ先（受診者・保護者以外の場合記入） | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 受診者との続柄 | | | | | |  |  | フリガナ | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 受診者との続柄 | | | | | |
| 氏名 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 氏名 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 住所 | | | 〒 | |  |  |  |  |  |  |  | □受診者と同じ（記載省略可） | | | | | | | | | | | |  |  | 住所 | | | 〒 | |  |  |  |  |  |  |  | □受診者と同じ（記載省略可） | | | | | | | | | | | |
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| 電話番号 | | | 自宅 |  |  |  |  |  |  |  |  |  | 携帯 |  |  |  |  |  |  |  |  |  |  |  |  | 電話番号 | | | 自宅 |  |  |  |  |  |  |  |  |  | 携帯 |  |  |  |  |  |  |  |  |  |  |
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