**様式第六の二**（附則第二条関係）

サービス提供証明書

（介護予防認知症対応型共同生活介護（短期利用以外））

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| 公費負担者番号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | 年 |  |  | 月分 | |
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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 | | | | | | |  | | | | | | | | | | | | | | | | | |
|  |  | | | 年 |  | |  | | | 月 |  | |  | | 日 | |
| 要支援  状態区分 | 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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| 入居  年月日 |  |  |  | 年 |  |  | 月 |  |  | 日 | 退居  年月日 |  |  |  | 年 |  |  | 月 |  |  | 日 | 入居実日数 |  |  | 外泊日数 |  |  |  |
| 入居前の状況 | | | | 1.居宅　2.医療機関　3.介護老人福祉施設　4.介護老人保健施設　5.介護療養型医療施設　6.認知症対応型共同生活介護  7.特定施設入居者生活介護　8.その他　9.介護医療院 | | | | | | | | | | | | | | | | | | | | | | | | |
| 退居後の状況 | | | | 1.居宅　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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| 給付費明細欄 | サービス内容 | サービスコード | | | | | | 単位数 | | | | 回数  日数 | | サービス単位数 | | | | | | 公費分  回数等 | | 公費対象単位数 | | | | | | 摘要 |
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| 合計 | | | | | | | | | | | | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |

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| 請求額集計欄 | 区分 | 保険分 | | | | | | 公費分 | | | | | |
| ①単位数合計 |  |  |  |  |  |  |  |  |  |  |  |  |
| ②単位数単価 |  |  |  |  | 円／単位 | |  | | | | | |
| ③給付率 |  |  |  | ／100 | | |  |  |  | ／100 | | |
| ④請求額（円） |  |  |  |  |  |  |  |  |  |  |  |  |
| ⑤利用者負担額（円） |  |  |  |  |  |  |  |  |  |  |  |  |

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