様式第12号(第20条関係) Form 12 (Article 20)											
		Appli (Child with dis					port for S New/ Rea) *1	
	Katakana	カナザワ ハルコ						Date of birth			
Patient	Name	Kanazawa Haruko						♦♦(Year) ♦♦(Month) ♦♦(Day)			
	Address	1-1-1 Hirosaka, Kanazawa						Tel	0-	76-123-4567	
	Individual Number	123456789012									
When the patient is a minor	Katakana							Relation to			
	Guardian's name							the patient			
	Guardian's address *2	Write the medical insurance					Tel Write the insurer's name and number of the health				
	Guardian's Individual Number	certificate code/No.					insurance certificate.				
self-pay amounts	Patient's health insurance code/No.	123 45		Insurer's name		K	(anazawa Cit	ty	Insurer's No.	170027	
	Insured person's name			Relation to the patient		Address	1-1-1 Hirosaka, Kana		azawa		
	Persons covered by the same insurance	Name		Individual Number		oer	Name			Individual Number	
		Kanazawa Ichiro	741852963074		Wri	Write the names and Individual					
Items related to		Taro		963852741096		6	Numbers of all the same insur		persons cov	ered by	
	Income category *3	Welfare · Low 1 · Low 2 · Middle 1 · Middle 2 · Higher than the					e standard	Severe and ongoing *3		Yes • No	
Pl	hysical disability certificate *4	Ishikawa Prefecture • Kanazawa City Grade:									
Medical institutions specified for medical support for the disabled (including pharmacies and home-visit nursing services)							ne physical disability ate grade, etc. Address/ Tel				
		OOO Hospital					○─○─○ Sainen, Kanazawa				
		△△△ Pharmacy					$\triangle-\triangle-\triangle$ Sainen, Kanazawa				
		Write the names of the medical institutions you visit the pharmacies you go to for prescriptions. Write all									
		institutions you use.					Τ) 			
I hereby apply for medical support for self-reliance.											
Αį	pplicant's name -	Kanazawa Haruko									
		♦♦ (Year) ♦ (Month)	♦ (Day	<i>'</i>)	(Address	see) Ma	ınager, Kar	nazawa Ci	ity Social Welfare Office	

Do not fill in the items below. 自治体記入欄 申請受付年月日 駅西・元町・泉野・本庁 認定年月日 重度かつ 生保・ ・ 低2 ・ 中間1 ・ 中間2 ・ 一定以上 非該当 前回所得区分 継続 重度か 生保 ・ 低1 ・ 低2 中間1 ・ 中間2 非該当 今回所得区分 該当 一定以上 標準負担額減額認定証 市民税課税•非課税証明書 市民税通知書 生活保護受給世帯の証明書 所得確認書類 その他収入等を証明する書類 税端末 変更の場合変更日 年 今回の受給者番号 有(80万円超・80万円以下)・ 特定疾病療養受療証 非課税収入 有 • 番号 通知 代理 法定 戸籍 住民 端末 本人 委任 考 個人 免許 手帳 在留 旅券 住基B 保険 介護 年金 その他(

^{*1:} Circle the appropriate category (Child with disability or Person with disability) and application type (New, Reapproval or Change (change of self-pay maximum or medical institutions)).

^{*2:} Write the address if it is different from the patient's address.

^{*3:} Refer to the check sheet and circle the appropriate category.

^{*4:} If you have a physical disability certificate, write the details.