付表６（共生型）【記入例】

共生型通所介護事業者の指定に係る記載事項

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 事　業　所 | | フリガナ | | | | | | ○○○○カイゴサービス | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 名　称 | | | | | | ○○○○介護サービス | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | | | | （郵便番号５９６－００７６）  大阪府岸和田市野田町○丁目○番○号　（ビルの場合は、名称、部屋番号を記載してください） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 連絡先 | | | | | | 電話番号 | | | | | | | 072-000-0000 | | | | | | | | | | | | | | | | | ＦＡＸ番号 | | | | | | | | | | | | | | | | | | | | | | 072-000-0000 | | | | | | | | | | | | | | |
| 指定障がい福祉  サービス等の種別 | | | | | | | | | | | | | 生活介護or自立訓練or  児童発達支援or  放課後等デイサービス | | | | | | | | | | | | | | | | | 指定障がい福祉  サービス等の事業所番号 | | | | | | | | | | | | | | | | | | | | | | ○○○○○○○○○○ | | | | | | | | | | | | | | |
| 当該事業の実施について定めてある定款・寄附行為等の条文 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 第〇〇条第〇〇項第〇〇号 | | | | | | | | | | | | | | | | | | | | | | | |
| 管　理　者 | | フリガナ | | | | | | ○○○○　○○○○ | | | | | | | | | | | | | | | | | | | | | | 住所･  連絡先 | | | | | | | | | （郵便番号５９６－００７３）  大阪府岸和田市岸城町○番○号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | | | | | | ○○　○○ | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | | | | | 昭和○○年○○月○○日生 | | | | | | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | 072-000-0000 | | | | | | | | | | | FAX番号 | | | | | 072-000-0000 | | | | | | |
| 他の職務との兼務の状況（兼務がある場合のみ記入） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 当該共生型通所介護事業所内での他の職務との兼務 | | | | | | | | | | | | | | | | | | | | | 職種 | | | | | | | | | | | （兼務する場合のみ記入） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 同一敷地内の他の事業所又は施設の職務との兼務 | | | | | | | | | | 事業所又は施設の名称及び事業又は施設の種類 | | | | | | | | | | | | | | | | | | | | | | | （訪問介護を兼務する場合）  ①訪問介護 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 兼務する職種及び勤務時間 | | | | | | | | | | | | | | | | | | | | | | | ①の管理者  月～金（9:00～18:00）８時間勤務／日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 実施単位数 | | | | | | １単位 | | | | | | | | 同時に共生型通所介護の提供を受けることができる利用者の数の上限 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 15人 | | | | | | | | | |
| 単位ごとの状況 | | | | | | | | | | | | | | | | １単位目 | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | 合　計 | | | | |
|  | 定　員 | | | | | | | | | | | | | | | 15　　 人 | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | 15人 | | | | |
| 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | 50　　　㎡ | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | 50㎡ | | | | |
| 単位別情報 | | 従業者 | | |  | | | | | | | サービス  管理責任者 | | | | | | | | | | | 医師 | | | | | | | | | | | 生活支援員 | | | | | | | | | | | | | 精神保健福祉士 | | | | | | | | | 看護職員 | | | | | | | | | 理学療法士等 | | | |
| 専従 | | | | | | 兼務 | | | | | 専従 | | | | 兼務 | | | | | | | 専従 | | | | | | | | 兼務 | | | | | 専従 | | | | 兼務 | | | | | 専従 | | | | 兼務 | | | | | 専従 | | 兼務 | |
| 常　勤(人) | | | | | | |  | | | | | | １ | | | | |  | | | |  | | | | | | | １ | | | | | | | |  | | | | |  | | | |  | | | | |  | | | |  | | | | |  | |  | |
| 非常勤(人) | | | | | | |  | | | | | |  | | | | |  | | | | １ | | | | | | | １ | | | | | | | |  | | | | |  | | | |  | | | | | １ | | | |  | | | | | １ | |  | |
| 定員 | | | | | | １５　人 | | | | | | | | | | | | 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ５０　㎡ | | | | | | | | | | | | | | | | |
| 営業日 | | | | | | 日 | | 月 | | | 火 | | | | 水 | | | 木 | | | | | | 金 | | | 土 | | | | 祝 | | | | | | | | その他年間の休日 | | | | | | | | | 8/13-8/15　　12/30-1/3  10月祭礼日 | | | | | | | | | | | | | | | | | | |
|  | | ○ | | | ○ | | | | ○ | | | ○ | | | | | | ○ | | | ○ | | | |  | | | | | | | |
| 営業時間 | | | | | | 平日 | | | 9：00 | | | | | | | | ～ | 18：00 | | | | | | | | | | | 土曜 | | | | | | | 9：00 | | | | | | ～ | | | | 18：00 | | | | | 日・祝 | | | | |  | | | | | ～ | | |  | | |
| 送迎を除くサービス提供時間 | | | | | | | | | | | | | | | | | | | 10：00　～　17：00　（　7　時間00　　分） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主な掲示事項 | | 利用料 | | | | | | | 法定代理受領分 | | | | | | | | | | | | | | | 介護報酬の告示上の額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法定代理受領分以外 | | | | | | | | | | | | | | | 介護報酬の告示上の額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| その他の費用 | | | | | | | 別添運営規程に定める料金のとおり | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通常の事業  実施地域 | | | | | | | ①岸和田市 | | | | | | | | | | | | | ②貝塚市 | | | | | | | | | | | | | | | | | | ③泉北郡忠岡町 | | | | | | | | | | | | ④和泉市 | | | | | | | | | ⑤泉大津市 | | | | | | | |
| 備考 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (療養型のみ）協力医療機関 | | | 名称 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | 主な診療科名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| 名称 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | 主な診療科名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| 名称 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | 主な診療科名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |

記入上の注意　１　記入欄が不足する場合は、別に記入した書類を添付すること。