付表６（共生型）

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 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 名　称 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | | | （郵便番号　　　－　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 連絡先 | | | | | 電話番号 | | | | | | | |  | | | | | | | | | | | | | | | | | | ＦＡＸ番号 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 指定障がい福祉  サービス等の種別 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | 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　　　条第　　　項第　　　号 | | | | | | | | | | | | | | | | | | |
| 管　理　者 | | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | 住所･  連絡先 | | | | | | | | （郵便番号　　　　－　　　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | |  | | | | | | | | FAX番号 | | | | |  | | | | |
| 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 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 兼務する職種及び勤務時間 | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 実施単位数 | | | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人 | | | | | | |
| 単位ごとの状況 | | | | | | | | | | | | | | | | １単位目 | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | 合　計 | | | | |
|  | 定　員 | | | | | | | | | | | | | | | 人 | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | 人 | | | | |
| 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | ㎡ | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | ㎡ | | | | |
| 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) | | | | | | | |  | | | | | |  | | | | |  | | | | | | | |  | | | | | | | |  | | |  | | | | | |  | | |  | | | | |  | |  | | | |  |  |
| 非常勤(人) | | | | | | | |  | | | | | |  | | | | |  | | | | | | | |  | | | | | | | |  | | |  | | | | | |  | | |  | | | | |  | |  | | | |  |  |
| 定員 | | | | | 人 | | | | | | | | | | | | | 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ㎡ | | | | | | | | | | | | | |
| 営業日 | | | | | 日 | | | 月 | | | 火 | | | | 水 | | | 木 | | | | | | 金 | | | 土 | | | | | 祝 | | | | | | その他年間の休日 | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | |  | | |  | | | |  | | |  | | | | | |  | | |  | | | | |  | | | | | |
| 営業時間 | | | | | 平日 | | | |  | | | | | | | | ～ |  | | | | | | | | | | | | 土曜 | | | | |  | | | | | | | ～ | | |  | | | 日・祝 | | | | |  | | | | ～ | |  | | |
| 送迎を除くサービス提供時間 | | | | | | | | | | | | | | | | | | | ：　　～　　：　　（　　　時間　　　分） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主な掲示事項 | | 利用料 | | | | | | 法定代理受領分 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法定代理受領分以外 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| その他の費用 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通常の事業  実施地域 | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | |
| 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。