付表２

地域密着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 | | | | | | | | | | |  | | | | | | | | | | | | | |
| メールアドレス | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | 同時に地域密着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 | | | | | | | | | | | ２単位目 | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | 合　計 | | |
|  | 定　員 | | | | | | | | | | | | | | | | | 人 | | | | | | | | | | | 人 | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | 人 | | |
| 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | | | ㎡ | | | | | | | | | | | ㎡ | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | ㎡ | | |
| 一般型・療養型の別 | | | | | | | | | | | | | | | | | 一般型・療養型 | | | | | | | | | | | 一般型・療養型 | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | |  | | |
| 単位別情報（１単位目） | | ※２単位目以降は、別紙に記載し、添付すること | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 従業者 | | |  | | | | | | | 生活相談員 | | | | | | | | | 看護師・准看護師 | | | | | | | | | | | | | | 介護職員 | | | | | | | | | 機能訓練指導員 | | | | | | | | 栄養職員 | | | | | | 歯科職員 | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 食事の提供に要する費用 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通常の事業実施地域 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (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 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |

備考　１　２単位以上実施する場合は、別紙に記載し、添付すること。

２　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。