**≪　　DO NOT FILL IN REFERENCE ONLY 記入しないでください。　≫**

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Application for Daycare Benefits for Disabled Children

And Deduction/Exemption

To Mayor of Toshima City

Date　　　　　YY MM DD

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| --- | --- | --- | --- | --- |
| Applicant | Katakana | 　 | Date of birth | YY MM DD　　 |
| N a m e | 　 |
| My Number | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Address | 〒Phone:　　　　　　　　　　　　　　　 |
| Katakana | 　 | Gender | M・F | Date of birth | YY MM DD |
| 　Name of child | 　 |
| Relation | 　 |
| My Number | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| PhysicalDisabilityCertificate | No. | Ai-no-techo | No. | Mental DisabilityHealth WelfareCertificate | No. | Name of disease | 　 |
| Code & No. of Health Insurance (※) | 　 | Insurer name and No.(※) |  |

(※)Fill in above two columns when you apply for medical services child developmental support

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| --- | --- | --- |
| Current status | Disability welfare services | Type and nature of services in use (Name of facility & days of use per month(e.g.) XXX facility - 2 days/mo. YYY facility - 3 days/mo. Total 5 days/mo. |
| Services to apply | Type of support | Details pertaining to the application |
| □　Child development support | Name of facility & days of use per month(e.g.) XXX facility - 2 days/mo. YYY facility - 3 days/mo. Total 5 days/mo. |
| □　Medical services child developmental Support |
| □　After-school daycare service |
| □　Home-visit type child development support |
| □　Visiting support to nursery schools |

Consent　(Check mark if you agree with the following items)

□　I consent to a survey of my and my household's circumstances, tax information and

entitlement status for the purpose of determining the fee.

(If you do not agree, or if we cannot verify your tax payment information because you

have moved in from outside the city, we will ask you to submit a certificate of residence

taxation or tax exemption for all of your household members.)

□　I agree that Toshima City may present all or part of the contents of the hearing on my

intention regarding the use of daycare support and the doctor's opinion to the relevant

persons at the designated consultation support provider for disabled children, daycare

support provider or residential facility for disabled children and the relevant departments

in the city office, when necessary for the preparation of a plan for use of support for

children with disabilities. (Continued on back page)

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| --- | --- | --- | --- | --- |
| Physician | Name | 　 | Name of clinic/hospital | 　 |
| Address | 〒　　 Phone:　　　　　　　　　　　　　 |

|  |  |
| --- | --- |
| Type of reduction or exemption | 　□　I.　Maximum monthly burden　　　　　I am applying for the following categories.　　　　 (Please circle that applies. If none of the below apply, leave blank.)　　　　1．Am receiving welfare　　　　2．Am exempted from residential tax　　　　3．Am levied for residential tax (Income tax rate \280,000 or less) ※　　　※ Received “housing loan deduction” or ”tax deduction for donations”Housing loan deduction　　 \　　　　　　　　　　　　　　　　Tax deduction for donation　　　　 \　　　　　　　　 |
| 　□　II.　 Multiple-children reduction　　　　　I am applying for the following categories. (Please circle that applies.)　　　　 1．Second child　　　　 2．Third child or onward　　　　 ※Proof of enrollment is required. |
| 　□　III.　Measures to prevent transition to welfare (reduction or exemption of fixed rate burden)　　　　　I apply for measures to prevent transition to welfare　　　　※Boundary layer eligibility certificate issued by the welfare office is required. |

The application must be accompanied by documentation that verifies the facts.

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| --- | --- |
| Applicant | □ Applicant self (No need to fill in below)　　□ Other |
| Name | 　 | Relation | 　 |
| Address | 〒Phone:　　　　　　　　　　　　　　　　　　 |