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Application for Daycare Benefits for Disabled Children And Deduction/Exemption

To Mayor of Toshima City

Date YY MM DD

Applicant	Katakana		Date of birth	YY MM DD
	Name			
	My Number			
	Address	〒 Phone:		
Katakana Name of child		Gender M・F	Date of birth	YY MM DD
My Number			Relation	
Physical Disability Certificate	No.	Ai-no-techo	No.	Mental Disability Health Welfare Certificate 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

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.

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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.

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