附件：1.2024年困难精神残疾人药费补助任务建议目标

　　　2.2024年残疾儿童康复救助任务建议目标

　　　3.2024年残疾人基本型辅助器具服务任务建议目标

4.困难精神残疾人药费补助审批表

　　　5.困难精神残疾人药费补助汇总表

　　　6.残疾儿童康复救助项目安置（转送）考核表

7.宿州市残疾人基本型辅助器具适配补贴申请审批表

8.残疾儿童辅助器具适配项目申请审批表

9.肢体辅具评估适配表

10.假肢处方表

11.矫形器处方表

12.视力辅具评估适配表

13.听力辅具评估适配表

14. 市（县、区）辅具适配登记汇总表

15.辅具产品验收情况表

附件1

2024年困难精神残疾人药费补助任务建议目标

|  |  |
| --- | --- |
| 县 区 | 困难精神残疾人药费补助（人） |
| 合 计 | 9444 |
| 埇桥区 | 3024 |
| 砀山县 | 1687 |
| 萧 县 | 1631 |
| 灵璧县 | 1697 |
| 泗 县 | 1405 |

附件2

2024年度残疾儿童康复救助任务建议目标

|  |  |
| --- | --- |
| 地 区 | 残疾儿童康复训练（人） |
| 合 计 | 1390 |
| 埇桥区 | 491 |
| 砀山县 | 222 |
| 萧 县 | 248 |
| 灵璧县 | 256 |
| 泗 县 | 173 |

附件3

2024年残疾人基本型辅助器具服务任务

建议目标

单位：人

|  |  |  |  |
| --- | --- | --- | --- |
| 地 区 | 辅具补贴任务数 | 儿童辅助器具 | 儿童假肢矫形器 |
| 合 计 | 3668 | 66 | 75 |
| 埇桥区 | 965 | 19 | 22 |
| 砀山县 | 656 | 10 | 12 |
| 萧 县 | 782 | 14 | 16 |
| 灵璧县 | 645 | 13 | 14 |
| 泗 县 | 620 | 10 | 11 |

附件4

困难精神残疾人药费补助审批表

**\_\_\_\_\_\_县（市、区）\_\_\_\_\_\_乡镇（街道）\_\_\_\_\_\_村（社区）**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓名 |  | 性别 |  | 残疾人证号 |  |
| 经济状况 | □ 1.低保户 □ 2.家庭经济困难 |
| 医保情况 | □ 1.城乡居民基本医疗保险 □ 2.医疗救助 □ 3. 其他医疗保险 □ 4.无医疗保险  |
| 银行账号或一卡通号 | 开户行：账号： |
| 监护人姓名 |  | 与患者关系 |  | 联系电话 |  |
| 监护人承诺 | 一、保证药费补助金按规定使用；二、监护病情，督促病人按时服药、体检和复查；三、自觉履行监护职责，接受社会各界监督。监护人签名： 年 月 日 |
| 乡镇(街道)残联意见 | 审核人：公章年 月 日 |
| 县（市、区）残联审批意见 | 审核人：公章年 月 日 |

注:本表由县（市、区）残联存档。

附件5

困难精神残疾人药费补助汇总表

**\_\_\_\_\_\_县（市、区）\_\_\_\_\_\_乡镇（街道） 年 月 日**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 序号 | 姓名 | 性别 | 残疾人证号 | 监护人姓名 | 家庭住址 | 联系电话 |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |

附件6

残疾儿童康复救助项目安置（转送）考核表

**\_\_\_\_\_\_市\_\_\_\_\_\_县(市、区)\_\_\_\_\_\_乡镇（街道）\_\_\_\_\_\_村（社区）**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 儿童姓名 |  | 性别 |  | 残疾类别 |  |
| 残疾人证或身份证号 |  |
| 家长（监护人）姓名 |  | 身份证号 |  |
| 联系电话 |  |
| 安置申请 | 申请前（转）往**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**定点机构接受训练。申请人（监护人）签字： 年 月 日 |
| 机构意见 | 定点机构（签章）年 月 日 |
| 计划康复起止日期 | 年 月至 年 月 |
| 户籍所在市或县级残联意见 | 同意转送安置。签字（公章）年 月 日 |
| 实际康复训练时间 | 年 月至 年 月 | 康复效果机构自评 | □显效 □有效 □一般 |
| 机构所在地（项目申请地）残联考核评估意见 | 签章: 年 月 日 |

附件7

宿州市残疾人基本型辅助器具适配补贴申请审批表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 申请人姓名 |  | 残疾类别 | 视力□　听力□　肢体□　智力□　精神□（多 重 残 疾 可多 选） | 残疾等级 | 一级□　二级□三级□　四级□　 未定级□ |
| 残疾人证/身份证号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 性 别 |  | 家庭地址 |  |
| 联系人 |  | 联系电话 |  |
| 申请适配辅具项目 |  | 辅具名称 | 数量 | 申请（代理）人签字 |
| 1 |  |  |  年 月 日 |
| 2 |  |  |
| 3 |  |  |
| 乡镇(街道)残联初审意见 | 审核人意见： 签字（公章）： 年 月 日  |
| 县(市、区)残联复审意见 | 审核人意见：  签字（公章）： 年 月 日  |

附件8

残疾儿童辅助器具适配项目申请审批表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 儿童姓名 |  | 性别 | 男□ 女□ | 民族 |  |
| 身份证号 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 家庭住址 |  | 联系电话 |  |
| 监护人姓名 |  | 工作单位 |  |
| 经济状况 | □家庭人均收入低于当地城乡居民最低生活保障线□家庭经济困难 | 户口类别 | □农业户口 □非农业户口 |
| 残疾状况 | □偏瘫 □截瘫 □脑瘫 □截肢 □其它 |
| 辅助器具需求情况 | 序号 | 产品名称及数量 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| 监护人申请 | 申请人： 年 月 日  |
| 县（市、区）残联复筛意见 |  |

说明：此表由市残联技术组指导救助儿童监护人填写，县（市、区）残联审核并存档备查，用√在□符合项中标出。

附件9

肢体辅具评估适配表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓名 |  | 性别 | 男□ 女□ | 出生日期 |  |
| 既往辅具名称 |  |
| 既往辅具使用情况 |  |
| 目前存在的主要问题 |  |
| 残疾人（包括监护人）对辅具的需求 |  |
| 技术组评估意见 | 辅具 矫形器 □踝足矫形器 □膝踝足矫形器 □矫形鞋□脊柱矫形器 □手部矫形器 假肢 □大腿假肢 □小腿假肢 □手部假肢 |
| 适配功能目标 |  |
| 本人或监护人（签字）： 技术组（签字）：年 月 日 |

附件10

假肢处方表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓名 |  | 性别 | 男 □ 女 □ | 出生日期 |  |
| 截肢部位 |  | 截肢时间 |  | 截肢原因 |  |
| 残肢评估 | 残肢形状 | 圆 柱 □ 圆 锥 □ 圆 锤 □ 畸 形 □ |
| 残肢表面 | 疤痕□ 神经瘤□ 囊肿□ 骨刺□ 其他□ |
| 残肢有关症状描述 |  |
| 假肢处方 | 假肢名称： 要 求：   |
| 监护人(签字) |  | 医师(签字) |  |

附件11

矫形器处方表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓 名 |  | 性 别 | 男□ 女□ | 出生日期 |  |
| 矫形器评估 | 下肢：肌力 左 右 左 右伸髋/外展 屈髋/内收伸膝 屈膝足跖屈 足背屈肌张力 |
| 屈髋肌群（伸、屈）屈膝肌群（伸、屈）足跖屈肌群（伸、屈）本体觉 | 挛缩□L□R挛缩□L□R挛缩□L□R | 紧张□L□R紧张□L□R紧张□L□R | 正常□L□R正常□L□R正常□L□R |
| 髋膝踝趾步态分析： | 良好□L□R 良好□L□R 良好□L□R 良好□L□R | 一般□L□R一般□L□R一般□L□R一般□L□R | 差□L□R差□L□R差□L□R差□L□R |  |
| 其他情况说明： |
| 矫形器处方 | □踝足矫形器（要求 )□膝踝足矫形器（要求 ）□其他矫形器  |
| 监护人(签字) |  | 医师(签字) |  |

附件12

视力辅具评估适配表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓名 |  | 性别 | □男 □女 | 出生日期 |  |
| 医疗机构诊断结果 | □遗传、先天异常或发育障碍 □白内障（术前/术后） □青光眼（术前/术后） □屈光不正 □黄斑部病变（术前/术后） □角膜浑浊 □视神经病变 □脑外伤 □眼外伤 □视网膜色素膜病变 □视网膜脱离（术前/术后） □弱视 □外伤 □中毒 □眼球震颤 □ 其他：  |
| 需求评估 |   |
| 目前使用助视器情况 | □无 □有，名称  |
| 视功能评估 | （包括远近视力、最佳矫正视力、屈光度数、中心视野检查、对比敏感度等） |
| 其他评估 | （包括阅读能力测试、定向行走测试等） |
| 适配建议 | 辅具名称 |  |
| 适配目的 |  |
| 评估人： 日期： |

附件13

听力辅具评估适配表

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 姓名 |  | 性别 | □男 □女 | 年龄 |  |
| 听障确诊时间 |  | 首次佩戴助听设备时间 | 左耳 |  |
| 右耳 |  |
| 补偿/重建方式 | 左耳 | □无 □助听器 □人工耳蜗 □其它 | 设备型号 |  |
| 右耳 | □无 □助听器 □人工耳蜗 □其它 |  |
| 听力测试 | 测听方法 □BOA □VRA □PA □PTA |
| 配合程度 □很配合 □一般 □不配合 |
| 测试音 □啭音 □纯音 □窄带噪音 □语音 |
| 听 力 图

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| dB-100102030405060708090100110120 | 125 250 500 1000 2000 4000 8000 Hz

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| 左耳(Left Ear) |

 |  | dB-100102030405060708090100110120 | 125 250 500 1000 2000 4000 8000 Hz

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 右耳(Right Ear) |

 |  |

|  |  |  |
| --- | --- | --- |
| 符号说明 | 未掩蔽 | 加掩蔽 |
| 左 右 | 左 右 |
| 气导骨导 | X O> < | □］ | △［ |

裸耳平均听阈 裸耳平均听阈   |
| 电生理测试 | 侧别 | 左耳 | 右耳 |
| 频率 | 0.5KHZ | 1KHZ | 2KHZ | 4KHZ | 0.5KHZ | 1KHZ | 2KHZ | 4KHZ |
| 听觉稳态电位测试（ASSR）单位：dBSPL/dBnHL |  |  |  |  |  |  |  |  |
| 目前存在主要需求 |  |
| 适配听力辅具名称 |  |
| 评估人： 评估日期： |
|  |

附件14

 市（县、区）辅具适配登记汇总表

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 序号 | 姓名 | 年龄 | 残疾证号 | 联系电话 | 辅具名称 | 数量 | 单位 | 补贴形式（实物/现金） | 辅具机构 | 联系电话 | 本人或监护人签字 | 是否进行宣教 |
| 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |  |

填表人： 市残联盖章：

注：假肢和矫形器单位均为例，一双代表2例。

附件15

辅具产品验收情况表

|  |  |
| --- | --- |
| 供应商名称 |  |
|  厂家联系人： |  厂家联系电话： |
| 序号验收内容 | 产品品名 | 产品型号 | 单位 | 数量 | 产品附加要素 | 与供应商投标文件中的承诺是否一致 | 备注（其它需要说明的内容） |
| 有无产品合格证 | 有无产品说明书 | 有无保修保养卡 |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |

验收单位（盖章）： 负责人： 联系电话： 填表日期：