Annual Health Statement for Developing Potential, Inc.

Individual Name: ____________________________ DOB: _______________

Day Habilitation – Mobility Exception

Individual requires mobility assistance by a trained staff in order to access and/or participate in community-based services to their fullest extent of their capabilities. Individual routinely needs an assistive device for mobility and/or requires supervision during ambulation. Assistance includes but not limited to: wheelchair, walker, fall risk, seizures.

In accordance with Medicaid Waiver Guidelines, does Individual meet Medical exception for Mobility criteria?

☐ **YES** ☐ **NO**

Please include any information and/or diagnosis that supports above statement:

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Physician Signature: _________________________________ Date: __________________
Physician Name (print):____________________________________
Physician Phone Number: ___________________