

¿Hablas Español? Si No
 ¿Necesitas un documento en Español? Si No

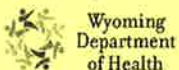
Aging Needs Evaluation Summary (AGNES) - One Form

This form may not be altered. Revised 6/7/19. Effective 7/1/19.

Basic Client Information		Date of Assessment: / /		Nickname:	
Legal First Name:		Legal Last Name:		Middle Initial:	
Date of Birth: / /	Age:	Gender (check one): <input type="checkbox"/> Female <input type="checkbox"/> Male		Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Residential Address:			<input type="checkbox"/> Check if same as Residential Address		
Mailing Address:					
Residential City, State and Zip Code:			Mailing City, State and Zip Code:		
County of Residence:			Email Address:		
Primary Phone Number: ()			Secondary Phone Number: ()		
Primary Language (check one) <input type="checkbox"/> English <input type="checkbox"/> Other		Race (check one) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/ Pacific Islander		Ethnicity (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you live in a rural area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you eligible for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you the spouse or dependent of a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your monthly income at or below this amount? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Family size 1-\$1,041		Family size 2- \$1,409		Family size 3- \$1,778 Family size 4- \$2,146	
Emergency contact name:		Relationship:		Phone number: ()	
Are you working? <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> No			Are you willing to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How did you hear about our services and what services are you interested in receiving?					
<p>Use of Information: The information you provide on the AGNES form will be disclosed to the Wyoming Department of Health (WDH), Aging Division, Community Living Section. The WDH will only use or disclose the information as permitted by the Health Insurance Portability and Accountability Act (HIPAA). For more detailed information on how the WDH may use or disclose your health information, please see the WDH Notice of Privacy Practices found online at https://health.wyo.gov/admin/privacy/ or you may request a copy from the WDH Aging Division by calling 1 (800) 442-2766. If you feel you have been treated inappropriately, received services that have not been of the quality expected, or you have not been provided services as stated in the service plan, you may contact the Wyoming State Long Term Care Ombudsman at 1 (800) 856-4398 or the WDH Aging Division, Community Living Section at 1 (800) 442-2766.</p>					

Signature _____ Date _____

*This page is for WDH, Aging Division Title III-B, C1, C2, D, E and WYHS eligible participants.



Aging Needs Evaluation Summary (AGNES) - One Form

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Nutrition Risk Assessment	YES (please circle)	NO (please circle)
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
I eat fewer than 2 meals per day.	3	0
I eat few (less than 3) fruits or vegetables or milk products.	2	0
I have 3 or more drinks of beer, liquor or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
I am not always physically able to shop, cook, and/or feed myself.	2	0
What is the consumer's nutrition risk score?- TOTAL (0-2= No Risk) (3-5= Moderate Risk) (6 or more= High Risk)		
Are you interested in receiving nutrition counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nutrition Risk Action	Nutrition Risk Score	
Reassess in 6-12 months.	0-2: No Risk	
Provide "Eating Well as We Age" booklet. Offer nutrition counseling services. Reassess in 3-6 months.	3-5: Moderate Risk	
Provide "Eating Well as We Age" booklet. Recommend that the client discusses their score with a dietitian or health professional. Offer nutrition counseling services.	6 or more: High Risk	

Office use only (eligibility checklist for Title III-C2)	
Is the client homebound or geographically isolated to justify home delivered meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eligibility Category: <input type="checkbox"/> 60 and older <input type="checkbox"/> Spouse <input type="checkbox"/> Disabled under 60 <input type="checkbox"/> Volunteer	
ADL total number: _____ ADL total score: _____	IADL total number: _____ IADL total score: _____
Comments/Notes:	

ACC Signature _____ Date _____

*This page is for WDH, Aging Division Title III-C1, C2, E and WYHS eligible participants.