¿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 4/12/2021.

Basic Client Information		**Date of Assessment:** / /	Nickname:
Legal First Name:		Legal Last Name:	Middle Initial:
Date of Birth: / /	Age:	Gender (check one): ❒Female ❒Male	Are you disabled? ❒Yes ❒No

Residential Address:	❒ *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) ❒English ❒Other	Race (check one) ❒ White ❒American Indian/Alaskan ❒ Asian ❒ Black/ African American ❒ Other ❒ Native Hawaiian/ Pacific Islander	Ethnicity (check one) ❒ Hispanic or Latino ❒ Not Hispanic or Latino

Are you married? ❒ Yes ❒ No ❒ Widowed ❒ Other	Do you live alone? ❒ Yes ❒ No	Do you live in a rural area? ❒ Yes ❒ No
Are you eligible for Medicaid? ❒ Yes ❒ No	Are you a veteran? ❒ Yes ❒ No	Are you the spouse or dependent of a veteran? ❒ Yes ❒ No

Is your monthly income at or below this amount? ❒ Yes ❒ No
Family size 1-$1,073 Family size 2- $1,452 Family size 3- $1,830 Family size 4- $2,208

Emergency contact name:	Relationship:	Phone number: ( )

Are you working? ❒ Full Time ❒ Part time ❒ No	Are you willing to volunteer? ❒ Yes ❒ No

How did you hear about our services and what services are you interested in receiving?

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.

Signature _____ **Date**_____

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

Wyoming Department of Health

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? ❒ Yes ❒ 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?	❒ Yes ❒ No
Eligibility Category: ❒ 60 and older ❒ Spouse ❒ Disabled under 60 ❒ 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.