¿Hablas Español? Si No **Aging Needs Evaluation Summary (AGNES) - One Form**

¿Necesitas un documento en Español? Si No **This form may not be altered. Revised 1/10/2024**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Provider please complete: What programs will the participant be enrolled in?***  **Title III-B** (Complete 1st page)  **Title III-C1** (Complete 1st & 2nd page)  **Title III-C2** (Complete 1st, 2nd, & 3rd page)  **Take Out Meals** (Complete 1st & 2nd page)  **Title III-D** (Complete 1st page)  **Title III-E** (Complete 1st, 2nd, & 3rd page)  **WyHS** (Complete 1st, 2nd, & 3rd page) | | | | | | | | | | | | |
| ***Client Please Complete: Basic Client Information*** | | | | | | | | | | | | |
| **Date of Assessment: / /**  Assessment date in A&D) | | | | | | | Nickname: | | | | | |
| Legal First Name: | | | Legal Last Name: | | | | | | | | | Middle Initial: |
| Date of Birth: | Age: | | Gender (check one): Female Male Other  *(Optional)* Non-Binary Non-Disclose Transgender-Female Transgender-Male Other | | | | | | | | | |
| / / |  | |
| Residential Address: | | | | | | *Check if same as Residential Address*  Mailing Address: | | | | | | |
| Residential City, State and Zip Code: | | | | | | Mailing City, State and Zip Code: | | | | | | |
| Primary Phone Number: ( ) | | | | | | Secondary Phone Number: ( ) | | | | | | |
| Phone Type:  *Cell*  *Home* | | | | | | Phone Type:  *Cell*  *Home* | | | | | | |
| Email Address: | | | | | | Are you willing to volunteer?  Yes  No | | | | | | |
| What is your preferred language?  English Spanish Other  List: | | Race (check one)  White, non-Hispanic  White-Hispanic American Indian/Native Alaskan  Asian or Asian American  Black/African American  Native Hawaiian/Pacific Islander  Other | | | | | | | | | Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino | |
| Marital Status? (check one) | | | | | Do you live alone? | | | | | Are you working?  Full Time  Part time  No | | |
| Single  Married  Widowed  Other | | | | | Yes  No | | | | |
| Are you disabled? 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-$1,255 Family size 2- $1,703 Family size 3- $2,152 Family size 4- $2,600 | | | | | | | | | | | | |
| Emergency contact name: | | | | Relationship: | | | | | Phone Number: ( )  Phone Type:  *Cell*  *Home* | | | |
| ***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.

**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 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** |
|  | **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** |
| Wh 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*** | |
| Good! Reassess in 6-12 months. | 0-2: No Risk | |
| Offer nutrition education and counseling services. Reassess in 3-6 months. | 3-5: Moderate Risk | |
| Recommend that the client discusses their score with a dietitian or health professional.  Offer nutrition education and counseling services. | 6 or more: High Risk | |

***Provider please complete: (Use this space to document any special needs or eligibility notes for all programs)***

Comments/Notes:

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