¿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 2/20/2026

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)
❒ **C1 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: / / (Today's date – Assessment date in A&D)	Nickname:

Legal First Name:	Legal Last Name:	Middle Initial:

Date of Birth: (mm/dd/yyyy) / /	Age:	Gender (check one): ❒Female ❒Male ❒Other ❒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: ( ) Phone Type: ❒ *Cell* ❒ *Home*	Secondary Phone Number: ( ) 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) ❒ Single ❒ Married ❒ Widowed ❒ Other	Do you live alone? ❒ Yes ❒ No	Are you working? ❒ Full Time ❒ Part time ❒ 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-$1,330 Family size 2- $1,803 Family size 3- $2,276 Family size 4- $2,750

(Optional) Are you a caregiver of a loved one? ❒Yes ❒No	Are you interested in caregiver services? If so, please mark 'yes' to allow Dept. of Health's providers to contact you about potential services. ❒Yes ❒No

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**_____

Wyoming Department of Health

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

Nutrition Screening	**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**
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)		
Staff Only: If High Risk: The Dietitian may contact the participant regarding their risk score to provide information that may be beneficial. Was the referral made to the RD?	❒ 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	

Staff Only: If Participant is Eligible for C2 Home Delivered Meals, Please Check a Reasoning:

- ☐ Unable to prepare their own meals due to ADL/IADL assessment
- ☐ Lacking meal support service in home or community
- ☐ Unable to consume meals at a congregate dining location due to physical or emotional difficulties
- ☐ Spouse of eligible participant
- ☐ Disabled person under 60 years who resides with eligible participant
- ☐ Staff members of the nutrition program who are 60 years of age or older
- ☐ Persons under 60 years of age who provide meal-related volunteer services

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