

¿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 2/3/2023.

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: / /	Age:	Gender (check one): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (Optional) Gender Identity for 'Other': <input type="checkbox"/> Non-Binary <input type="checkbox"/> Non-Disclose <input type="checkbox"/> Transgender-Female <input type="checkbox"/> Transgender-Male <input type="checkbox"/> Other	
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:	
Primary Phone Number: () Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home		Secondary Phone Number: () Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home	
Email Address:		Are you willing to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your preferred language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other List: _____	Race (check one) <input type="checkbox"/> White, non-Hispanic <input type="checkbox"/> White-Hispanic <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other		Ethnicity (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Marital Status? (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you working? <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> No
Are you disabled? <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? Family size 1-\$1,215 Family size 2- \$1,643		<input type="checkbox"/> Yes <input type="checkbox"/> No Family size 3- \$2,072 Family size 4- \$2,500	
Emergency contact name:	Relationship:	Phone Number: () Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home	
<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 _____	
<p>Office use only: What programs will the participant be enrolled in? <input type="checkbox"/> Title III-B <input type="checkbox"/> Title III-C1 <input type="checkbox"/> Title III-C2 <input type="checkbox"/> Title III-D <input type="checkbox"/> Title III-E <input type="checkbox"/> WyHS</p>			

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



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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
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		
<i>Nutrition Risk Action</i>	<i>Nutrition Risk Score</i>	
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	

Office use only: (Use this space to document any special needs or eligibility notes for all programs)
 Comments/Notes:

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