Wyoming Department of Health

AGING NEEDS EVALUATION SUMMARY (AGNES)
AGING DIVISION

 Date:

Legal Name:

_____(_____)
FIRST MI LAST Nickname

Mailing Address:

City State Zip Code County

Street Address (if different than mailing):

City State Zip Code County

Date of Birth _____ _____ Female _____ Male

Telephone Number(s)
Home (_____)_____-_____ Cell (_____)_____-_____

Language Spoken: _____

Do you have difficulty reading and/or writing? _____ YES ____NO
Do you require a translator or reader? _____YES ____NO
Do you live in a rural area ? _____ YES ____NO
(Answer NO, if you live in Casper, Cheyenne, Gillette, Laramie, or Rock Springs.)

Do you live alone? ___YES ___NO Are you disabled? ___ Yes ___ No
Are you a veteran? _____ YES _____ NO
Are you the spouse or dependent of a veteran? _____ YES _____ NO

Race
___White ___ Black/African American
___ Asian ___ American Indian/Alaska Native
___ Native Hawaiian/Pacific Islander
___ Other, please list_____

Ethnicity
___ Hispanic/Latino
___ Not Hispanic/Latino

Marital Status:
_____ Single/Widowed _____ Married
Spouse Name _____
Spouse Birthdate _____

Is your current family gross monthly income at or below this amount?
___ YES ___ NO

FAMILY SIZE 1 - $990 **FAMILY SIZE 3 - $1,680**
FAMILY SIZE 2 - $1,335 **FAMILY SIZE 4 - $2,025**

This form may not be altered. Revised 12/2016; 01/2017

Name of Emergency Contact Person(s)and Relationship to You:

First Name Last Name Relationship
Mailing Address
City State Zip
Telephone Number(s) _____

First Name Last Name Relationship
Mailing Address
City State Zip
Telephone Number(s) _____

MSC / / SAMS / /

Wyoming Department of Health
Commit to your health.

AGING NEEDS EVALUATION SUMMARY (AGNES)
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Legal Name_____

Nutritional Risk Assessment (Please Circle Yes or No)

I have an illness or condition that changes the kind or amount of food I eat.	Yes(2)	No(0)
I eat fewer than 2 meals every day.	Yes(3)	No(0)
I eat fewer (less than 5) servings of vegetables or fruit, or milk products per day.	Yes(2)	No(0)
I have 3 or more drinks of beer, wine or hard liquor every day.	Yes(2)	No(0)
I have tooth, mouth or swallowing problems that make it difficult to eat.	Yes(2)	No(0)
I eat alone most of the time.	Yes(1)	No(0)
I take 3 or more different prescribed or over-the-counter medications daily.	Yes(1)	No(0)
I am not always physically able to shop, cook and/or feed myself.	Yes(2)	No(0)
I have unintentionally lost or gained 10 pounds in the past 6 months.	Yes(2)	No(0)
Sometimes, I do not have enough money to buy food.	Yes(4)	No(0)
Nutritional Risk Score:		_____

LOW RISK 0-2 MODERATE RISK 3-5 HIGH RISK 6-21

FOR OFFICE USE ONLY:

Nutritional Risk Score	-Nutrition Risk Action
0-2 Low Risk	- Recheck in 12 months
3-5 Moderate Risk	- Provide "Eating Well as We Age Brochure" or similar information. Offer Nutrition Counseling services
6 or more High Risk	- Recommend to client that he or she discuss their nutritional risk score with their dietitian or health professional or offer Nutrition Counseling services. Provide "Eating Well as We Age Brochure".

Eligibility Checklist for Title IIIC2 (Home Delivered Meals) – Please circle Yes or No:

Person homebound because of geographical isolation (outside the boundaries of public transportation service area): Y N
Homebound on recommendation of medical practitioner (frail health, illness or disability): Y N
Homebound due to mental or social limitations or isolation: Y N
ADL (number 2 or more): _____ IADL (number 2 or more): _____

NSIP Eligibility Type if age 59 and younger: Disabled in Elderly Housing Disabled Living with Elderly Person Spouse Volunteer (18 and older)

Please Circle type of evaluation: Short Form: B C1 D =1-3 pages Medium Form: C2 = 1-4 pages
Long Form: E-Care Receiver WyHS = 1-8 pages

Ask client if they want a copy of this document for their records

PERSON ASSISTING AND REVIEWING FORM (print in blue ink): _____

RELEASE OF INFORMATION

I hereby give my permission for Eppson Center for Seniors [SERVICE PROVIDER] to share information contained in the Aging Needs Evaluation Summary (AGNES) and other program documentation with the Wyoming Aging Division and other affiliated service providers for the purpose of program evaluation for the Administration on Aging and State of Wyoming grant programs.

Information received will be treated as **confidential** and will only be made available in accordance with the requirements of law.

I may cancel this release at any time except to the extent that action has been taken in reliance on it. This release expires automatically one year from the date of my signature.

If I do not sign this release for the purposes described above, I may be required to pay for any services I have received or be solely responsible for payment of services.

If I am denied program services, I may be entitled to a review by the Service Provider. Contact your service provider to inquire about their review policy or procedure.

I have the right to review and/or obtain a copy of my record including an accounting of any disclosures made from my record.

If I feel information in my record is invalid, I may make a written request for an amendment of the record.

If I feel I have been treated inappropriately, services have not been of the quality expected and/or not provided as stated in the service plan; I may contact the Wyoming State Long Term Care Ombudsman at **(800)-856-4398** or the WDH Aging Division, Community Living Section at **(800) 442-2766.**

For additional information regarding the WDH's Privacy Policy, visit the WDH's Office of Privacy, Security and Contracts' website: https://health.wyo.gov/admin/privacy/

I have read and agree with this form.

Client or Representative's Signature (in blue ink):_____
Date: _____

Authority and Relationship of Representative (if any) signing on Client's behalf

_____

Witness (in blue ink):_____ **Date:** _____
(Put N/A if client signs for them self. If the client cannot sign, uses an X or stamp then the ACC or person assisting in filling out the AGNES will sign as a Witness.) Make a copy for the Client.