

¿Hablas Español? Si No

¿Necesitas un documento en Español? Si No

### Agging Needs Evaluation Summary (AGNES) - One Form

This form may not be altered. Revised 6/7/19. Effective 7/1/19.

<b>Basic Client Information</b>		<b>Date of Assessment:</b> /        /		Nickname:	
Legal First Name:		Legal Last Name:		Middle Initial:	
Date of Birth: /        /	Age:	Gender (check one): <input type="checkbox"/> Female <input type="checkbox"/> Male		Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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:			
County of Residence:		Email Address:			
Primary Phone Number: (    )		Secondary Phone Number: (    )			
Primary Language (check one) <input type="checkbox"/> English <input type="checkbox"/> Other		Race (check one) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/ Pacific Islander		Ethnicity (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you live in a rural area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you eligible for Medicaid? <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?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Family size 1-\$1,041		Family size 2- \$1,409		Family size 3- \$1,778	
		Family size 4- \$2,146			
Emergency contact name:		Relationship:		Phone number: (    )	
Are you working? <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> No		Are you willing to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you hear about our services and what services are you interested in receiving?					
<p><b>Use of Information:</b> 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 <a href="https://health.wyo.gov/admin/privacy/">https://health.wyo.gov/admin/privacy/</a> 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 \_\_\_\_\_

\*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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<b>Nutrition Risk Assessment</b>	<b>YES</b> (please circle)	<b>NO</b> (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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b><i>Nutrition Risk Action</i></b>	<b><i>Nutrition Risk Score</i></b>	
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	

<b><i>Office use only (eligibility checklist for Title III-C2)</i></b>	
Is the client homebound or geographically isolated to justify home delivered meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eligibility Category: <input type="checkbox"/> 60 and older <input type="checkbox"/> Spouse <input type="checkbox"/> Disabled under 60 <input type="checkbox"/> Volunteer	
ADL total number: _____ ADL total score: _____	IADL total number: _____ IADL total score: _____
Comments/Notes:	

**ACC Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Aging Needs Evaluation Summary (AGNES) - One Form

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Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
<b>0</b> Independent <b>2</b> Intermittent supervision/ minimal assistance <b>4</b> Partial assistance <b>6</b> Total dependence	<b>Rate client's ability to perform BATHING.</b>	<b>0</b> Independent/ prepares simple or partial meals <b>1</b> Prepares with verbal cueing or reminding <b>2</b> Prepares with minimal help <b>3</b> Does not prepare any meals	<b>Rate client's ability to PREPARE MEALS.</b>
<b>0</b> Independent <b>2</b> Intermittent supervision/ minimal assistance <b>4</b> Extensive help <b>6</b> Total dependence	<b>Rate client's ability to EAT.</b>	<b>0</b> Independent <b>2</b> Does with supervision/reminding <b>4</b> Shops with hands-on help/ assistive devices <b>6</b> Done by others or shops by phone	<b>Rate client's ability to perform SHOPPING.</b>
<b>0</b> Independent <b>1</b> Limited physical assistance <b>2</b> Extensive assistance <b>3</b> Total dependence	<b>Rate client's mobility IN HOME.</b>	<b>0</b> Independent/ does not occur <b>2</b> Done with help some of the time <b>4</b> Done with help all of the time	<b>Rate client's ability to MANAGE MEDICATIONS.</b>
<b>0</b> Independent <b>1</b> Limited physical assistance <b>2</b> Extensive assistance <b>3</b> Total dependence	<b>Rate client's ability to perform TRANSER.</b>	<b>0</b> Completely independent <b>2</b> Needs assistance sometimes <b>4</b> Needs assistance most of the time <b>6</b> Completely dependent	<b>Rate client's ability to MANAGE MONEY.</b>
<b>0</b> Independent <b>2</b> Reminding, cueing or monitoring <b>4</b> Limited physical assistance <b>6</b> Extensive assistance <b>8</b> Total dependence	<b>Rate client's ability to perform TOILETING.</b>	<b>0</b> Independent <b>1</b> Needs assistance sometimes <b>2</b> Needs assistance most of the time <b>3</b> Unable to perform tasks	<b>Rate the client's ability to perform LIGHT HOUSEWORK.</b>
<b>0</b> Independent <b>1</b> Limited physical assistance <b>2</b> Reminding, cueing or monitoring <b>3</b> Extensive assistance <b>4</b> Total dependence	<b>Rate client's ability to perform DRESSING.</b>	<b>0</b> Independent <b>1</b> Needs assistance sometimes <b>2</b> Does with maximum help <b>3</b> Unable to perform tasks	<b>Rate the client's ability to perform HEAVY HOUSEWORK.</b>
<b>ACC Signature:</b> _____ <b>Date:</b> _____ <b>Quarter Period:</b> _____  <b>ADL Total Number:</b> _____ <b>ADL Total Score:</b> _____  <b>IADL Total Number:</b> _____ <b>IADL Total Score:</b> _____ <b>Eligible Participant Initials:</b> _____		<b>0</b> Independent <b>1</b> Can perform with some help <b>2</b> Cannot perform function at all without help	<b>Rate client's ability to USE THE TELEPHONE.</b>
		<b>0</b> Independent <b>1</b> Done with help some of the time <b>2</b> Done by others <b>3</b> Requires ambulance	<b>Rate the client's ability to access TRANSPORTATION.</b>

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## Aging Needs Evaluation Summary (AGNES) - One Form

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<b>Home Visit Evaluation for WyHS and Caregiver Programs</b>	<b>YES</b>	<b>NO</b>
Does the client have safe access to all necessary areas of his/her home?		
Are the steps and walkways outside the client's home in good condition?		
Is the client's home free of cluttered/soiled living area?		
Is there adequate/proper food storage?		
Is the client's home free of insects/rodents?		
Is the client's home free from odors?		
Is there any indoor toileting facility?		
Is the bathroom adequate to meet the client's needs?		
Is there adequate sewage disposal?		
Is there a trash removal service?		
Is the client able to unlock doors and/or windows?		
Do kitchen appliances work properly?		
Does the client have both running water and hot water?		
Can the temperature of the client's home be controlled to suit their needs?		
Is there access to a telephone/ cell phone?		
Is the client's home free of electrical hazards?		
Is the client's home free from fire hazards (i.e. frayed cords, items next to heater, etc.)?		
Are smoke detectors present and in working order?		
Are carbon monoxide detectors present and in working order?		
In the case of an emergency, would the client be able to get out of his/her home safely on their own?		
Are pets living in the home well managed?		
Comments or notes:		
<b>ACC Signature:</b> _____ <b>Date:</b> _____		

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<b>0</b> Independent <b>1</b> Limited physical assistance <b>2</b> Extensive assistance <b>3</b> Total dependence	<b>Rate client's mobility IN HOME.</b>	<b>0</b> Independent/ does not occur <b>2</b> Done with help some of the time <b>4</b> Done with help all of the time	<b>Rate client's ability to MANAGE MEDICATIONS.</b>
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