¿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 4/12/2021.**

| ***Basic Client Information*** | | **Date of Assessment:** / / | Nickname: |
|---|---|---|---|
| Legal First Name: | | Legal Last Name: | Middle Initial: |
| Date of Birth: / / | Age: | Gender (check one): ❒Female ❒Male | Are you disabled? ❒Yes ❒No |
| Residential Address: | | ❒ *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) ❒English ❒Other | Race (check one) ❒ White ❒American Indian/Alaskan ❒ Asian ❒ Black/ African American ❒ Other ❒ Native Hawaiian/ Pacific Islander | Ethnicity (check one) ❒ Hispanic or Latino ❒ Not Hispanic or Latino |
|---|---|---|

| Are you married? ❒ Yes ❒ No ❒ Widowed ❒ Other | Do you live alone? ❒ Yes ❒ No | Do you live in a rural area? ❒ Yes ❒ No |
|---|---|---|

| Are you eligible for Medicaid? ❒ 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-$1,073 Family size 2- $1,452 Family size 3- $1,830 Family size 4- $2,208

| Emergency contact name: | Relationship: | Phone number: ( ) |
|---|---|---|

| Are you working? ❒ Full Time ❒ Part time ❒ No | Are you willing to volunteer? ❒ Yes ❒ No |
|---|---|

How did you hear about our services and what services are you interested in receiving?

***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.

Wyoming Department of Health

| **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 (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<br>(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*** |
|---|---|
| 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 |

| ***Office use only (eligibility checklist for Title III-C2)*** | |
|---|---|
| Is the client homebound or geographically isolated to justify home delivered meals? | ❒ Yes ❒ No |
| Eligibility Category: ❒ 60 and older ❒ Spouse ❒ Disabled under 60 ❒ Volunteer | |
| ADL total number: _____ ADL total score: _____ | IADL total number: _____ IADL total score: _____ |
| Comments/Notes: | |

**ACC Signature** _____ **Date**_____

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

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

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

| **Home Visit Evaluation for WyHS and Caregiver Programs** | **YES** | **NO** |
|---|---|---|
| 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: | | |

**ACC Signature:** _____ **Date:** _____

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| Score | ADLs (Activities of Daily Living) | Score | IADLs (Instrumental Activities of Daily Living) |
|---|---|---|---|
| | **Rate client's ability to perform BATHING.** | | **Rate client's ability to PREPARE MEALS.** |
| **0** | Independent | **0** | Independent/ prepares simple or partial meals |
| **2** | Intermittent supervision/ minimal assistance | **1** | Prepares with verbal cueing or reminding |
| **4** | Partial assistance | **2** | Prepares with minimal help |
| **6** | Total dependence | **3** | Does not prepare any meals |
| | **Rate client's ability to EAT.** | | **Rate client's ability to perform SHOPPING.** |
| **0** | Independent | **0** | Independent |
| **2** | Intermittent supervision/ minimal assistance | **2** | Does with supervision/reminding |
| **4** | Extensive help | **4** | Shops with hands-on help/ assistive devices |
| **6** | Total dependence | **6** | Done by others or shops by phone |
| | **Rate client's mobility IN HOME.** | | **Rate client's ability to MANAGE MEDICATIONS.** |
| **0** | Independent | **0** | Independent/ does not occur |
| **1** | Limited physical assistance | **2** | Done with help some of the time |
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| | **Rate client's ability to perform TRANSFER.** | | **Rate client's ability to MANAGE MONEY.** |
| **0** | Independent | **0** | Completely independent |
| **1** | Limited physical assistance | **2** | Needs assistance sometimes |
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| **3** | Total dependence | **6** | Completely dependent |
| | **Rate client's ability to perform TOILETING.** | | **Rate the client's ability to perform LIGHT HOUSEWORK.** |
| **0** | Independent | **0** | Independent |
| **2** | Reminding, cueing or monitoring | **1** | Needs assistance sometimes |
| **4** | Limited physical assistance | **2** | Needs assistance most of the time |
| **6** | Extensive assistance | **3** | Unable to perform tasks |
| **8** | Total dependence | | |
| | **Rate client's ability to perform DRESSING.** | | **Rate the client's ability to perform HEAVY HOUSEWORK.** |
| **0** | Independent | **0** | Independent |
| **1** | Limited physical assistance | **1** | Needs assistance sometimes |
| **2** | Reminding, cueing or monitoring | **2** | Does with maximum help |
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