

¿Hablas Español? Si No

# Aging Needs Evaluation Summary (AGNES) - One Form

¿Necesitas un documento en Español? Si No

This form **may not** be altered. Revised 10/17/2024

## Provider please complete: What programs will the participant be enrolled in?

- Title III-B** (Complete 1<sup>st</sup> page)    **Title III-C1** (Complete 1<sup>st</sup> & 2<sup>nd</sup> page)    **Title III-C2** (Complete 1<sup>st</sup>, 2<sup>nd</sup>, & 3<sup>rd</sup> page)  
 **C1 Take Out Meals** (Complete 1<sup>st</sup> & 2<sup>nd</sup> page)    **C2 Take Out Meals** (Complete 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> page)    **Title III-D** (Complete 1<sup>st</sup> page)    **Title III-E** (Complete 1<sup>st</sup>, 2<sup>nd</sup>, & 3<sup>rd</sup> page)    **WyHS** (Complete 1<sup>st</sup>, 2<sup>nd</sup>, & 3<sup>rd</sup> page)

## Client Please Complete: Basic Client Information

<b>Date of Assessment:</b> /       / <small>(Today's date – Assessment date in A&amp;D)</small>	Nickname:
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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 <small>(Optional) Gender Identity for 'Other':</small> <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"/> <small>Check if same as Residential Address</small> Mailing Address:
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Residential City, State and Zip Code:	Mailing City, State and Zip Code:
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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
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Email Address:	Are you willing to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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
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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
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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
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Is your monthly income at or below this amount? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Family size 1-\$1,255	Family size 2- \$1,703	Family size 3- \$2,152	Family size 4- \$2,600

Emergency contact name:	Relationship:	Phone Number: (    ) Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home
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**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.

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<b>Nutrition Screening</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.	<b>2</b>	<b>0</b>
I eat fewer than 2 meals per day.	<b>3</b>	<b>0</b>
I eat few fruits or vegetables or milk products.	<b>2</b>	<b>0</b>
I have 3 or more drinks of beer, liquor or wine almost every day.	<b>2</b>	<b>0</b>
I have tooth or mouth problems that make it hard for me to eat.	<b>2</b>	<b>0</b>
I don't always have enough money to buy the food I need.	<b>4</b>	<b>0</b>
I eat alone most of the time.	<b>1</b>	<b>0</b>
I take 3 or more different prescribed or over-the-counter drugs a day.	<b>1</b>	<b>0</b>
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<b>2</b>	<b>0</b>
I am not always physically able to shop, cook, and/or feed myself.	<b>2</b>	<b>0</b>
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b><i>Nutrition Risk Action</i></b>	<b><i>Nutrition Risk Score</i></b>	
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: <b>High Risk</b>	

Staff Only: If Participant is Eligible for C2 Home Delivered Meals or C2 Take Out 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

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

This form may not be altered. Revised 10/17/2024.

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> Requires assistance sometimes <b>2</b> Totally dependent	<b>Rate client's Bowel/Bladder CONTINENCE.</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 TRANSFER.</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> No setup or physical help/ Independent <b>1</b> Supervision/cueing required <b>2</b> Totally dependent	<b>Rate the client's ability to perform LAUNDRY.</b>
<b>Staff 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>

\*This page is for WDH, Aging Division Title III-B (Chore Services Only), Title III-C2, Title III-E and WYHS eligible participants. Initial ADL/IADL for new assessment or renewal, to be completed by an ACC, or your organization's program support staff.

## 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> Requires assistance sometimes <b>2</b> Totally dependent	<b>Rate client's Bowel/Bladder CONTINENCE.</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 TRANSFER.</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>
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<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> No setup or physical help/ Independent <b>1</b> Supervision/cueing required <b>2</b> Totally dependent	<b>Rate the client's ability to perform LAUNDRY.</b>
<b>Staff 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>

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

Quarterly ADL/IADL, to be completed by an ACC.

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

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<b>Staff 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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Quarterly ADL/IADL, to be completed by an ACC.

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<b>Staff 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>
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