Wyoming Department of Health

AGING DIVISION – DOCUMENT 10-01-2010
AGING NEEDS EVALUATION SUMMARY (AGNES)
Client Name_____

Site location: AC Service provider: Date:

Name: _____
FIRST MI LAST

Nickname, if any

Mailing Address:

City State Zip Code

Street Address:

City State Zip Code

Birth date _____ _____ Female _____ Male

Telephone Number(s)
Home (_____)_____-_____ cell or message (_____)_____-_____

In the past year, have you received services from more than one Wyoming Senior Center? _____NO _____ YES

- If yes, where: _____
- Did you complete this form and sign a Release? _____ NO _____ YES

Do you have difficulty reading or writing? _____ NO____YES
Do you require an interpreter or reader? _____NO____YES

Emergency Contact Information

Name of Emergency Contact Person

Mailing Address

City

State ZIP code

Telephone number(s)

Relationship to you, if any_____

Do you live in a rural area ? _____ NO _____ YES

(Answer no, if you live in Casper, Cheyenne, Gillette, Laramie, or Rock Springs. All other areas of state should be marked rural)

Language spoken
_____ English _____ Spanish
_____ Russian _____ Other
_____ Native American _____ Asian
Please list other: _____

Marital Status
_____ Single/Widowed _____ Married
Spouse Name _____
Spouse Birth date _____

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Do you live alone ___NO ___YES	Are you a veteran? _____ NO _____ YES (served active duty and honorably discharged) Are you a spouse or dependant of a veteran? _____ NO _____ YES
Race ___White ___ Black/African American ___ Asian, Specify nationality_____ ___ Native American____ Pacific Islander ___ Other, please list_____	Ethnicity ___ Hispanic/Latino Other, please specify: _____ Do you have a heart condition? ___ NO ___ YES Do you have diabetes? ___ NO ___YES
Are you a caregiver_____No _____Yes Is the person you give care to: (a) over 60 (b) have Alzheimer's or related Dementia (c) An adult with disabilities or (d) a minor child 18 or younger (Caregiver must 55 or older for c and d, otherwise Caregiver can be 19 and older) ____No ____Yes Person you care for:_____ Address_____ Phone Number _____ Date of Birth _____ Gender ___Female ____Male Relationship to You _____	Have you ever had a pneumonia shot? ____NO ____YES Have a flu shot this year? ____NO ____YES Have you received information about the shingles vaccine? ____NO ____YES Is your family gross annual income at or below this amount _____ NO _____ YES **FAMILY SIZE 1 - $10,830 FAMILY SIZE 3 - $18,310** **FAMILY SIZE 2 - $14,570 FAMILY SIZE 4 - $22,050**

Nutritional Risk Assessment if you are 60 years or older or eligible

I have an Illness or condition that changes the kind or amount of food I eat.	___Yes (2)
I eat fewer that two (2) meals per day.	___Yes (3)
I eat fewer than 5 servings (1/2 cup each) of fruits or vegetables daily.	___Yes (1)
I eat/drink fewer than two servings of dairy (milk/cheese) products daily.	___Yes(1)
I have 3 or more drinks of beers, wine or hard liquor daily.	___Yes(2)
I have tooth, mouth or swallowing problems that make it difficult to eat.	___Yes(2)
I eat alone most of the time.	___Yes (1)
I take 3 or more different prescribed or over-the-counter medications daily.	___Yes (1)
I am not always able to shop, cook and/or feed myself.	___Yes(2)
I have unintentionally lost or gained 10 pounds in the past 6 months.	___Yes(2)
Sometimes, I do not have enough money to buy food.	___Yes(4)
Nutritional Risk Score:	_____
High Risk – 6 or more points Moderate Risk - 3-5 points Low Risk – 0-2 points	

Type of evaluation: **Initial evaluation:** B/C1/ D; C2/Care Receiver/CBIHS/ B (IHS)
Re-evaluation: B/C1/ D; C2/Care Receiver/CBIHS/ B (IHS)

PERSON REVIEWING FORM: _____

RELEASE OF INFORMATION

I hereby give my permission for _____ [SERVICE PROVIDER] to share information contained in the AGING NEEDS EVALUATION SUMMARY and other program documentation with the Aging Division and other affiliated service providers for the purpose of eligibility for the Administration on Aging and State of Wyoming **grant programs** such as supportive services, congregate meals, home-delivered meals, preventive services, community in-home services, family caregiver services.

Further, I understand that: By agreeing to take part in this program I give my permission to the service provider(s), Wyoming Department of Health (WDH), Aging Division, and the Administration on Aging (AoA) to share information obtained for the purpose of program evaluation and oversight.

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, and that in any event 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 hearing.

I have the right 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. I have been provided a copy of this form.

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 Long Term Care Ombudsman at **(800)-856-4398)** or the WDH Aging Division at **(800) 442-2766.** For additional information regarding the Wyoming Department of Health's privacy policy, visit the WDH Department's HIPAA website: http://www.health.wyo.gov/main/hipaa.html or call De Anna Greene, WDH HIPAA Compliance Officer at **(307) 777-8664**.

Client or Representative's Signature: _____

Date: _____

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

_____

Witness: _____ **Date:** _____

Nutritional Risk Score	-Nutrition Risk Action
0-2 Low Risk	- Recheck in 12 months
3-5 Moderate Risk	- Recheck in 3-6 months, Provide "Eating Well as We Age Brochure" or similar information.
6 or more High Risk	- Recommend to client he/she discuss the nutritional health with their health professional or dietitian. Client is at high nutritional risk.