

**KENTUCKY TRANSITIONS
SCREENING TOOL (KTST)**

Participant: _____

Screening Date: ____/____/____

Member ID #: _____

Review Date: ____/____/____

RT: _____

90 Day Eligibility Requirement Met: Yes No

Review Date: ____/____/____

ST: _____

Acuity Determination: _____

Information shall be gathered through assessment/observation/interview of the resident, nursing facility staff interviews, and clinical record review. Special attention should be made to documentation within the past 30 days and any recent updates to the MDS.

“Non-Weight-Bearing assist” includes guided maneuvering of limbs. **“Physical assist”** includes any need for weigh-bearing assist.

	LEVEL 1	LEVEL 2	LEVEL 3
BED MOBILITY	<input type="checkbox"/> Independent or Standby or non-weight-bearing assist to change position,	<input type="checkbox"/> Requires physical assist of one person,	<input type="checkbox"/> Requires physical assist of 2 or more persons.
TRANSFER	<input type="checkbox"/> Independent or Standby or non-weight-bearing assist to move to/from surfaces,	<input type="checkbox"/> Requires physical help of one person.	<input type="checkbox"/> Requires physical assist of 2 or more persons.
EATING/FEEDING	<input type="checkbox"/> Independent or May require setup assist or oversight, encouragement, cueing.	<input type="checkbox"/> Requires physical assist of one person.	<input type="checkbox"/> Requires physical assist of 2 or more person.
TOILETING	<input type="checkbox"/> Independent or Occasionally incontinent requiring physical assist.	<input type="checkbox"/> Requires physical assist of one person.	<input type="checkbox"/> Requires physical assist of 2 or more person.
PERSONAL HYGIENE	<input type="checkbox"/> Independent or Supervision required, but requires physical assist with bathing, dressing, grooming.	<input type="checkbox"/> Requires physical assist of one person.	<input type="checkbox"/> Requires physical assist of 2 or more persons.
COGNITION / BEHAVIOR	<input type="checkbox"/> No problems.	<input type="checkbox"/> Decisions poor (e.g., cues, supervision required), behavior indicators present but easily altered.	<input type="checkbox"/> Severely impaired (e.g., never or rarely makes decisions/behavior indicators present and not easily altered).
MEDICAL CONDITION	<input type="checkbox"/> Stable with routine medical/nursing monitoring and care.	<input type="checkbox"/> Requires frequent monitoring to maintain stability (e.g., unstable condition requiring frequent assessment and medication adjustment).	<input type="checkbox"/> Requires intense professional intervention to maintain stability (e.g., unstable diabetes, coma, terminal illness).
MEDICAL / NURSING TREATMENTS	<input type="checkbox"/> None / Routine (e.g., ROM, injections, routine catheter care, medication administrations.	<input type="checkbox"/> Requires skilled treatment in addition to routine medication administration, (e.g., sterile dressings, new colostomy, etc.).	<input type="checkbox"/> Requires intensive professional intervention to provide skilled treatment (e.g., tracheotomy, IV access, NG/G Tube care, extensive decub ulcers, etc).
COMMUNICATION	<input type="checkbox"/> No problem, able to understand and be understood. Able to make needs known, May require communication tools, board.	<input type="checkbox"/> Usually understood. May have difficulty (e.g., finding words), responds best to simple, direct communication.	<input type="checkbox"/> Rarely /Never able to understand or to make self understood. Unable to make needs known.

Score: **Level 1:** _____

Level 2: _____

Level 3: _____