TEXAS Health and Human Services | Texas Department of State Health Services

Correctional Tuberculosis Screening Plan (TB-805) Checklist

The checklist is a tool for **jail administrators or designees** to use when completing the correctional tuberculosis screening plan. Please note the checklist is **not** comprehensive for all form questions and/or situations.

Ensure the screening plan is complete before submitting for review and approval. If you have any questions, please email your local or regional health department.

Facility Name: _____ **Date Completed:** _____

Question #	QA Question	Yes	No	N/A	Notes
A9	Does the medical director have one of the following credentials: MD, DO, NP, or PA-C?	☐	☐	☐	
A11	If the contact person is not the same as the jail administrator (refer to question A10), is at least one contact person listed?	☐	☐	☐	
Section A	Is Section A complete (i.e., no missing information)?	☐	☐	☐	
B1	If "Other (Specify)," is selected, is the information provided?	☐	☐	☐	
B8	If "Federal," is selected, is at least one facility type (ICE, BOP, USMS) selected?	☐	☐	☐	
B8	If "Out-of-County" or "Out-of-State," is selected, are the counties and/or states specified?	☐	☐	☐	

Created 8/2024

Question #	QA Question	Yes	No	N/A	Notes
B9	Is a copy of the **current** contract for the healthcare team attached? **Note**: Current contracts are active through the approval period, i.e., 2025, or automatically renewed.	☐	☐	☐	
B10	Are the remaining questions completed if the medical provider is the same as in question A9?	☐	☐	☐	
B10	Is a copy of the **current** contract for the medical provider attached? **Note**: Current contracts are active through the approval period, i.e., 2025, or automatically renewed.	☐	☐	☐	
B13	If needed, was a separate sheet with the names **and** credentials attached?	☐	☐	☐	
B14	Are blood tests (e.g., QFTs and/or T-SPOTs) used to screen for TB?	☐	☐	☐	
B15	If TST is only used to screen for TB, was N/A written for this question?	☐	☐	☐	
B15	If blood tests are used, is the providing entity listed? **Note**: TB Programs cannot use DSHS-funded services (e.g., Quest) to provide IGRA testing for Chapter 89-designated facilities.	☐	☐	☐	
B16	Is the information on the chest x-ray provider appropriately filled out?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
B17	If "NO" is selected, is the appropriate information filled out?	☐	☐	☐	
B18	If the facility will relocate, was the location specified?	☐	☐	☐	
B19	If the TB infection control person is NOT the same as the contact person in Section A, was the appropriate information filled out?	☐	☐	☐	
B20	If the facility has AIIRs, is the number of AIIRs indicated?	☐	☐	☐	
B21	If the facility has fewer than two AIIRs, is the hospital/facility name provided where inmates will be isolated?	☐	☐	☐	
B21	Is a copy of the contract or agreement with the hospital/facility attached?	☐	☐	☐	
B22	If "YES" is selected, is the information provided on who oversees inspection and maintenance?	☐	☐	☐	
B22	If "NO" is selected, is the reason for not routinely inspecting and maintaining AIIRs at the facility provided?	☐	☐	☐	
B24	Is the correct contact person(s) listed? Contact the health department to verify this information.	☐	☐	☐	
B26 and B27	If the health department provides testing supplies, is it reflected accurately? Ensure the full spelling of the health department.	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
B26 and B27	Is the full name and address of the supplying entity provided?	☐	☐	☐	
B28	If the health department is the supplier of TB medications, does the health department serve as the medical provider (refer to question B10)? **Note:** The health department may review medication orders but shall not supply medications directly to Chapter 89-designated facilities unless the health department serves as the TB medical provider listed on the Correctional TB Screening Plan.	☐	☐	☐	
B29	Are the services checked consistent with what is provided by your local or regional TB Program? Contact the health department to verify services.	☐	☐	☐	
Section B	Is Section B complete (i.e., no missing information)?	☐	☐	☐	
C1	Is AM or PM specified for the facility shift hours if not using a 24-hour format?	☐	☐	☐	
C3	Are TSTs read within 48-72 hours of placement?	☐	☐	☐	
C4	If symptom screenings are conducted, is it specified when they are performed?	☐	☐	☐	
C4	Is a copy of the TB symptom screening form attached?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
	Note: The form must be a TB-specific symptom screening form or include TB-specific symptoms. You may choose to use the DSHS TB symptom screening form in your facility.				
C6	If the facility does not offer treatment for TB infection, are the circumstances provided?	☐	☐	☐	
C7	If "On a designated month" is selected, is the month specified?	☐	☐	☐	
C7	If "Other" is selected, is it specified when annual screenings occur?	☐	☐	☐	
C8	Is a copy of the continuity of care plan attached?	☐	☐	☐	
C12	Are all applicable transfer forms attached?	☐	☐	☐	
Section C	Is Section C complete (i.e., no missing information)?	☐	☐	☐	
D1	If "Other" is selected, is it specified when initial screenings occur?	☐	☐	☐	
D2	If "On a designated month" is selected, is the month specified?	☐	☐	☐	
D2	If "Other" is selected, is it specified when annual screenings occur?	☐	☐	☐	
Section D	Is Section D complete (i.e., no missing information)?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
E3	If "Other" is selected, is it specified when initial screenings occur?	☐	☐	☐	
E4	If "On a designated month" is selected, is the month specified?	☐	☐	☐	
E4	If "Other" is selected, is it specified when annual screenings occur?	☐	☐	☐	
Section E	Is Section E complete (no missing information)?	☐	☐	☐	
F1	If "YES," is selected, is the appropriate information provided?	☐	☐	☐	
Section G	Is the correct submission type selected?	☐	☐	☐	
END PAGE	Did the jail administrator sign and date the plan?	☐	☐	☐	

Supporting Document	Yes	No	N/A	Notes
Current Health Care team provider contract (question B9)	☐	☐	☐	
Current Medical service provider contract (question B10)	☐	☐	☐	
Staff and their credentials (question B13)	☐	☐	☐	

Supporting Document	Yes	No	N/A	Notes
Contract or agreement with hospital/facility (question B21)	☐	☐	☐	
TB symptom screening form (question C4)	☐	☐	☐	
Continuity of Care Plan (question C8)	☐	☐	☐	
Form(s) used to transfer inmate records (question C12)	☐	☐	☐	

I am confirming I have completed the screening plan and the above checklist to ensure its completion and accuracy. I am submitting a complete and accurate plan for review and approval.

Name: _____ **Date:** _____

Signature: _____