



CORRECTIONAL TUBERCULOSIS SCREENING PLAN

Refer to publication #TB-805-I for instructions filling this form. **Type or print neatly in black ink.** All sections of the plan must be filled out completely. **Do not leave questions blank (write N/A if needed).** **Do not use correction fluid.** The **signed original plan** must be mailed to Texas Department of State Health Services (DSHS) Tuberculosis and Hansen's Disease Branch. Download the plan from: www.texas.tb.org/forms/default.asp#jails. If assistance is needed, contact the Congregate Settings Team at (512) 533-3000.

A. CONTACT INFORMATION

1. Facility Name

2. Physical Address *(List additional sites in Section F)* **City** **State** **ZIP Code**

3. Mailing Address **City** **State** **ZIP Code**

4. Jail Administrator's Name	5. Phone Number	6. Fax Number
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7. Email Address	8. Title
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9. Medical Director

Name	Credentials
Phone Number	Address
City	State ZIP Code

10. Is the Contact Person the same as the Jail Administrator?
 YES NO If NO, complete question 11 below.

11. Contact Person, if different from Jail Administrator
 N/A

Name: Phone: Email Address:

Title:

B. FACILITY INFORMATION

1. Facility Operated By: <input type="checkbox"/> County <input type="checkbox"/> Private <input type="checkbox"/> Other	2. Name of the Operating Agency/Company	3. Facility Accreditation/Certification <input type="checkbox"/> ACA <input type="checkbox"/> NCCHC <input type="checkbox"/> Joint Commission <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other <i>(specify)</i>
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4. Total Number of Employees	5. TCJS Bed Capacity	6. Current Population
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23. Are AIIRs routinely inspected and maintained?

___ YES ___ NO ___ N/A

24. What is the name and title of the facility person who contacts the local (or regional) health department about TB suspects and/or cases in custody?

Name and title:

Phone:

25. Who provides medical care for inmates?

___ County Provider name(s)

___ Private

___ Hospital

Do you have a contract with this service provider? (If YES, attach a copy of the contract)

___ YES ___ NO

26. Who supplies TB testing materials for inmates? (PPD, Syringes)

___ Pharmacy

___ Health department

___ Other (specify)

Supplier name(s):

27. Provide name, mailing address, and telephone number of local (or regional) health department and the name of their contact person.

Health department:

Contact name and title:

Phone:

Address:

City: State: ZIP:

28. What TB services, if any, does your local (or regional) health department provide to your facility? (Select all that apply)

___ PPD

___ Syringes

___ Testing

___ Contact Investigation

___ Education

___ N/A

___ TB Medication

___ Other (please specify)

C. INMATE SCREENING

1. On which days and shifts are tuberculin skin tests or IGRA administered? (Select all that apply)

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday ___ Sunday

Facility shift hours when tuberculin skin test or IGRA are done. From: _____ To: _____

2. How soon after incarceration are inmates given a tuberculin skin test or IGRA?

Within _____ hours _____ days

3. How long after placing the skin test is it read? (please indicate a range)

Within _____ to _____ hours

Within _____ to _____ days

4. Are symptom screens conducted?

___ YES ___ NO

(If YES, attach a copy of your facility's TB symptom screening form)

If YES, when is it done?

5. For inmates with newly positive IGRA/TB skin tests results, when are chest x-rays done?

___ within 24 hours ___ 15-30 days

___ 2-7 days ___ Other (specify)

___ 8-14 days

6. Do you offer treatment for latent TB infection?

___ YES ___ NO

Note: Routine chest x-rays are not required for asymptomatic persons who have negative TB skin test results. After the initial chest radiograph is taken, persons with positive tuberculin skin-test reactions do not need repeat chest radiographs, unless symptoms develop that may be due to TB.

[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=97&rl=174](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=97&rl=174)

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7. When do annual screenings of long term inmates take place? <input type="checkbox"/> 12 months after the last test <input type="checkbox"/> On a designated Month <input type="checkbox"/> Other (specify)	8. Do you have a TB discharge plan for inmates scheduled for release into the community? <input type="checkbox"/> YES <input type="checkbox"/> NO
9. Who maintains inmate screening records? Name: Phone:	10. Who is responsible for sending transfer records to TDCJ or other correctional facilities on inmates with TB? Name: Phone:

All inmates shall be evaluated for TB infection and disease. All treatment must be documented. A record of treatment (TB400A and TB-400B) must be completed and submitted to the local (or regional) health department TB program located in the county of the facility. Form TB400A & TB-400B and other forms are available at: <http://www.texas.tb.org/forms/#reporting>.

11. Which form(s) are used to transfer inmate records? Check all that apply. (Please Attach a copy of the form(s))

Not Applicable Texas Uniform Health Status Form
 Alien in Transit Other (specify)

D. EMPLOYEE SCREENING

1. When do initial employee screenings take place? (Please check *all* boxes showing when screenings occur)

Prior to employment Within 7 days of starting work Other (specify)

2. When do annual employee screenings take place?

12 months from date of hire On a designated Month Other (specify)

3. If an employee has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. The employee must provide a physician certification indicating "no active disease."

How many days are allowed for the employee to submit this certification?

Days: _____

4. Who is responsible for keeping employee certificate records?

Name: _____ Phone: _____

E. VOLUNTEER SCREENING

1. Do volunteers provide services in your facility?

YES NO

2. When do initial volunteer screenings take place?

Not Applicable Prior to becoming a volunteer Other (specify)

NO VOLUNTEERS in facility work more than 30 hours per month Within 7 days of starting volunteer work

3. When do annual screenings take place?

Not Applicable 12 months from date of hire Other (specify)

NO VOLUNTEERS in facility work more than 30 hours per month Designated Month

4. Who is responsible for receiving physician certifications and monitoring TB screening?

Not Applicable NO VOLUNTEERS in facility work more than 30 hours per month

Name: _____ Phone: _____

If a volunteer has a positive reaction (10mm or greater,) they must provide a statement from a physician documenting the absence of active disease. Volunteers shall not re-enter facility without a physician statement.

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F. ADDITIONAL SITES: (Refer to Section A2)

1. Does your facility have additional sites? (If YES, enter the names and location of additional sites)

___ YES ___ NO

Facility Name			
Physical Address	City	State	ZIP Code
Mailing Address (If different from physical address) City State ZIP Code			
Jail Administrator		Phone Number	Fax Number
Email Address	Title		
Name and Title of Contact Person		Phone Number	Email Address

Facility Name			
Physical Address	City	State	ZIP Code
Mailing Address (If different from physical address) City State ZIP Code			
Jail Administrator		Phone Number	Fax Number
Email Address	Title		
Name and Title of Contact Person		Phone Number	Email Address

Facility Name			
Physical Address	City	State	ZIP Code
Mailing Address (If different from physical address) City State ZIP Code			
Jail Administrator		Phone Number	Fax Number
Email Address	Title		
Name and Title of Contact Person		Phone Number	Email Address

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Physical Address	City	State	ZIP Code
Mailing Address <i>(If different from physical address)</i>			
City	State	ZIP Code	
Jail Administrator		Phone Number	Fax Number
Email Address		Title	
Name and Title of Contact Person		Phone Number	Email Address

Facility Name			
Physical Address	City	State	ZIP Code
Mailing Address <i>(If different from physical address)</i>			
City	State	ZIP Code	
Jail Administrator		Phone Number	Fax Number
Email Address		Title	
Name and Title of Contact Person		Phone Number	Email Address

Facility Name			
Physical Address	City	State	ZIP Code
Mailing Address <i>(If different from physical address)</i>			
City	State	ZIP Code	
Jail Administrator		Phone Number	Fax Number
Email Address		Title	
Name and Title of Contact Person		Phone Number	Email Address

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G. PLAN SUBMISSION AND ACKNOWLEDGEMENT

Submission Type: *(select one)*

Annual plan

Amended plan

Please read the following statement carefully and indicate your understanding and acceptance by signing in the space provided.

Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter H, Sec. 97.173, C, ii requires that every inmate shall have a screening test for tuberculosis on or before the seventh day of incarceration and at least annually thereafter if the inmate is not known to be a previous positive reactor. More frequent TB screening is recommended when a specific situation indicates an increased risk of transmission. Texas Health and Safety Code Chapter 89 Sec. 89.102 also requires corrections facilities to report to the local health department the release of an offender who is receiving treatment for tuberculosis. The local health department shall arrange for inmate continuity of care.

By signing this form I acknowledge that I understand the above requirements.

This plan must be signed.

ORIGINAL SIGNATURE – Jail Administrator

Date

Date Plan Submitted: _____

H. APPROVAL

Mail the signed original plan to Texas Department of State Health Services, Tuberculosis and Hansen's Disease Branch, where the plan, once approved, will be maintained:

**Texas Department of State Health Services
Tuberculosis and Hansen's Disease Branch
PO Box 149347, MC 1939
Austin TX 78714-9347
(512) 533-3000**

The Texas Commission on Jail Standards will be notified of the initial approval, expiration, and renewal of your Correctional Tuberculosis Screening Plan. The approval is valid for one year beginning with the effective date shown below.

DSHS OFFICE USE ONLY

Approval Date: _____ **Effective Date:** _____ **Expiration Date:** _____

Approved by: _____ **Name:** _____
Signature Print

Title: Tuberculosis and Hansen's Disease Branch Manager

Submission date to local health department (LHD) or DSHS Health Service Region (HSR): _____

Name of LHD/HSR contact(s): _____