TEXAS
Health and Human Services

Texas Department of State Health Services

Correctional TB Training: Correctional Tuberculosis Screening Plan (TB-805)

Continuing Quality Improvement (CQI) Team
Tuberculosis and Hansen's Disease Unit

2026 Correctional TB Screening Plan Training Dates

- Wednesday, August 20, 2025
  - 9:00 – 10:00 AM
- Tuesday, August 26, 2025
  - 1:00 – 2:00 PM
- Friday, September 5, 2025
  - 9:00 – 10:00 AM

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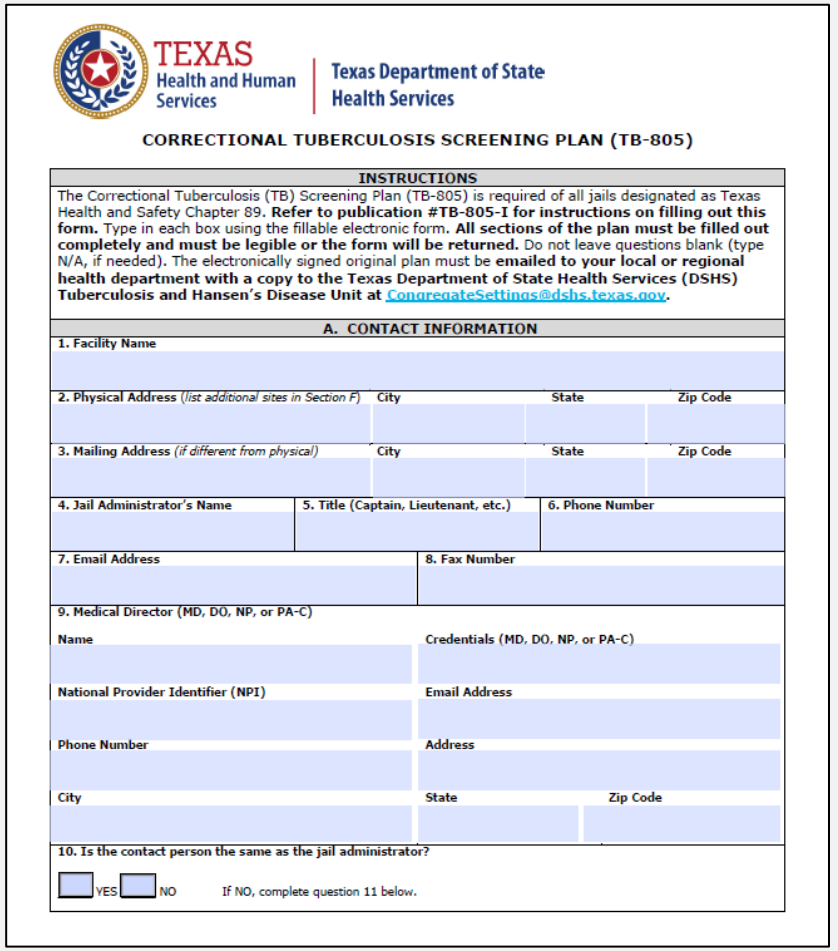
Learning Objectives

- ❑ Understand the purpose of the Correctional Tuberculosis Screening Plan (TB-805)
- ❑ Understand the process for screening plan renewal and approval
- ❑ Recognize key information listed in each section
- ❑ Understand the new changes to the 2026 TB-805

Purpose of the Correctional Tuberculosis Screening Plan (TB-805)

- Framework for the implementation and monitoring of legally required TB prevention and care standards for Chapter 89-designated facilities
- Requirement of the Texas Administrative Code (TAC)
  - Title 25, Part 1, Chapter 97, Subchapter H
  - Title 37, Part 9, Chapter 273
- Determine compliance with the Texas Health and Safety Code (HSC) and the TAC



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CORRECTIONAL TUBERCULOSIS SCREENING PLAN (TB-805)

INSTRUCTIONS

The Correctional Tuberculosis (TB) Screening Plan (TB-805) is required of all jails designated as Texas Health and Safety Chapter 89. **Refer to publication #TB-805-I for instructions on filling out this form.** Type in each box using the fillable electronic form. **All sections of the plan must be filled out completely and must be legible or the form will be returned.** Do not leave questions blank (type N/A, if needed). The electronically signed original plan must be **emailed to your local or regional health department with a copy to the Texas Department of State Health Services (DSHS) Tuberculosis and Hansen's Disease Unit at** CongregateSettings@dshs.texas.gov.

A. CONTACT INFORMATION

1. Facility Name

2. Physical Address *(list additional sites in Section F)* | City | State | Zip Code

3. Mailing Address *(if different from physical)* | City | State | Zip Code

4. Jail Administrator's Name | 5. Title (Captain, Lieutenant, etc.) | 6. Phone Number

7. Email Address | 8. Fax Number

9. Medical Director (MD, DO, NP, or PA-C)

Name | Credentials (MD, DO, NP, or PA-C)

National Provider Identifier (NPI) | Email Address

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.

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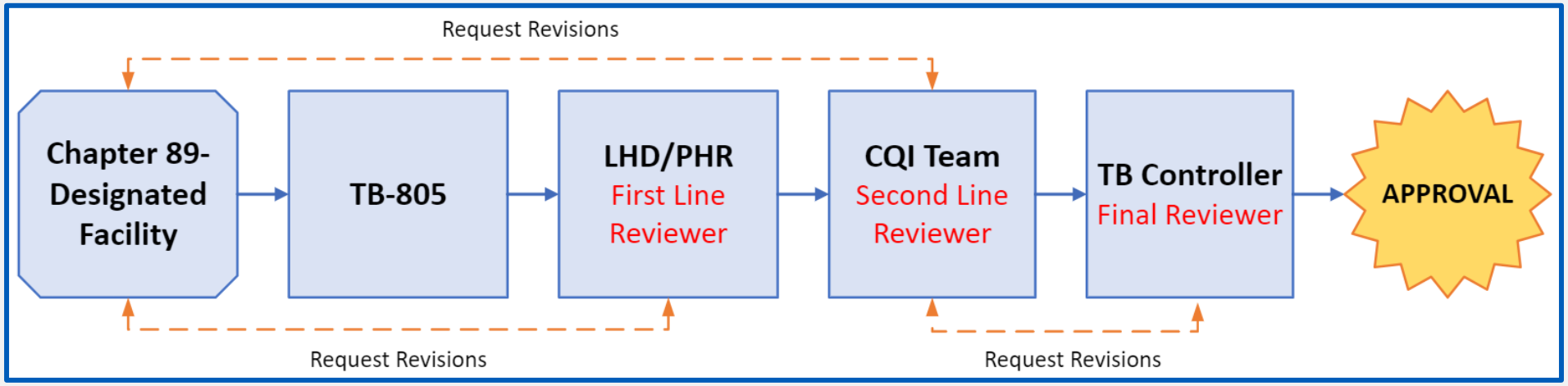
Renewal Process for TB-805

- The facility will submit the TB-805 to its local or regional TB program for **first-line review** with a copy to CongregateSettings@dshs.texas.gov

- Local or regional TB programs will send screening plans to CongregateSettings@dshs.texas.gov
  - Health departments have two weeks to review and submit to the CQI Team

- Renewal process flow chart for the 2026 TB-805:



TB-805 Important Dates

Submission Period

- September 8, 2025 to November 7, 2025

Approval Period

- January 1, 2026 to December 31, 2026
- Delinquent screening plans will have a truncated approval period

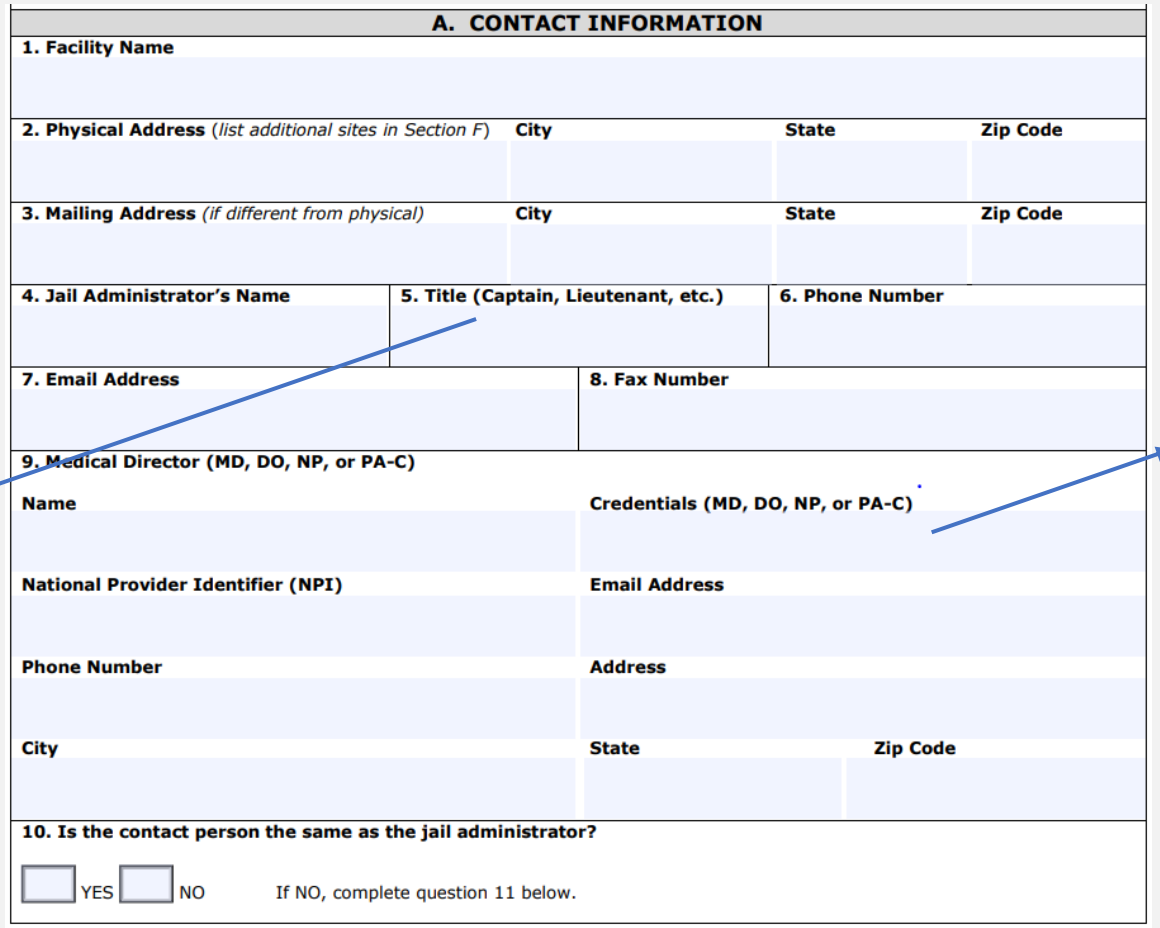
Submission & Reminder Process for TB-805

- Facilities must submit screening plans to their regional or local health departments by **November 7, 2025,** with a copy also sent to CongregateSettings@dshs.texas.gov

- **Chapter 89-designated facilities will receive reminder emails on the following dates:**
  - September 8, 2025: 60-day notification
  - October 8, 2025: 30-day notification
  - October 24, 2025: Two-week notification
  - October 31, 2025: One-week notification

Section A. Contact Information

Section A. Contact Information



A. CONTACT INFORMATION

1. Facility Name

2. Physical Address *(list additional sites in Section F)* | **City** | **State** | **Zip Code**

3. Mailing Address *(if different from physical)* | **City** | **State** | **Zip Code**

4. Jail Administrator's Name | **5. Title (Captain, Lieutenant, etc.)** | **6. Phone Number**

7. Email Address | **8. Fax Number**

9. Medical Director (MD, DO, NP, or PA-C)

Name | **Credentials (MD, DO, NP, or PA-C)**

National Provider Identifier (NPI) | **Email Address**

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.

Examples of jail administrator's title.

Credential **must** be MD, DO, NP, or PA-C.

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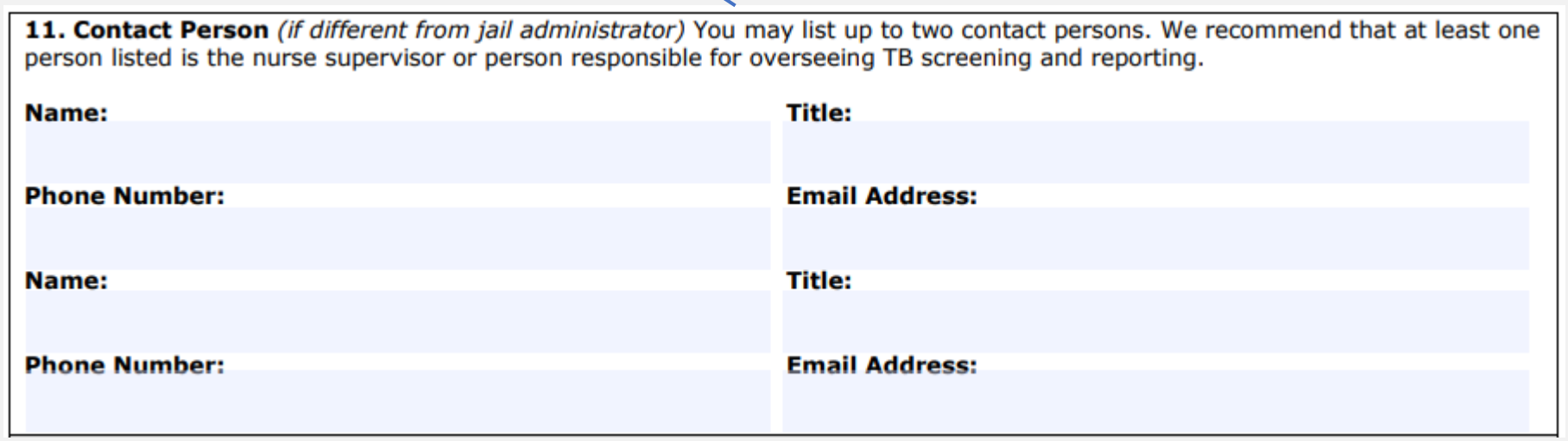
Section A. Contact Information (continued)

Up to two contact persons can be listed.



11. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.

Name:	**Title:**
Phone Number:	**Email Address:**
Name:	**Title:**
Phone Number:	**Email Address:**

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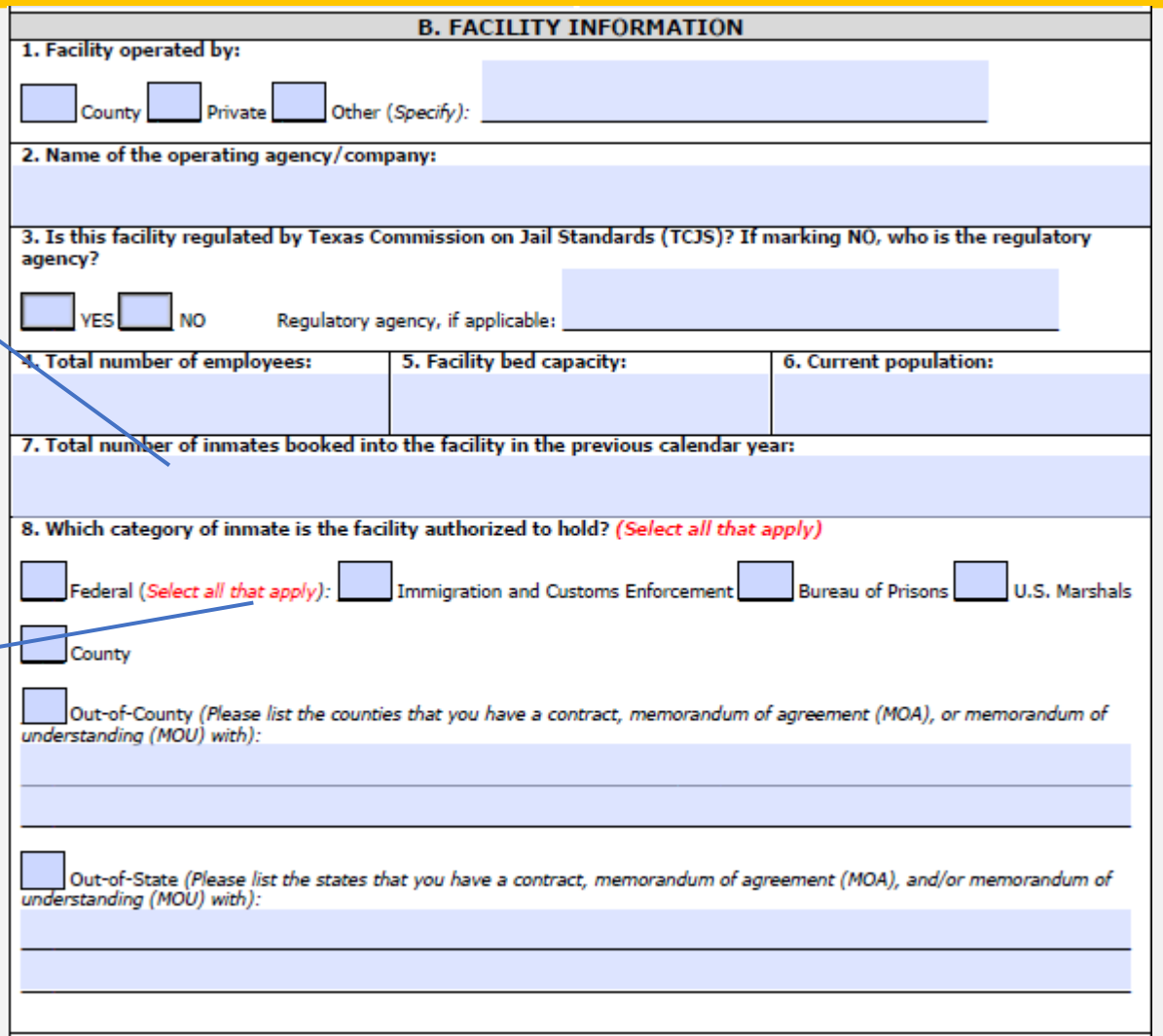
Section B. Facility Information

Section B. Facility Information

List the total number of inmates **booked into the facility** in the previous calendar year.

Facility should check **all** applicable federal inmates that they house.



B. FACILITY INFORMATION

1. Facility operated by:

☐ County ☐ Private ☐ Other (*Specify*): _____

2. Name of the operating agency/company:

3. Is this facility regulated by Texas Commission on Jail Standards (TCJS)? If marking NO, who is the regulatory agency?

☐ YES ☐ NO Regulatory agency, if applicable: _____

4. Total number of employees:	**5. Facility bed capacity:**	**6. Current population:**

7. Total number of inmates booked into the facility in the previous calendar year:

8. Which category of inmate is the facility authorized to hold? *(Select all that apply)*

☐ Federal (*Select all that apply*): ☐ Immigration and Customs Enforcement ☐ Bureau of Prisons ☐ U.S. Marshals

☐ County

☐ Out-of-County *(Please list the counties that you have a contract, memorandum of agreement (MOA), or memorandum of understanding (MOU) with):*

☐ Out-of-State *(Please list the states that you have a contract, memorandum of agreement (MOA), and/or memorandum of understanding (MOU) with):*

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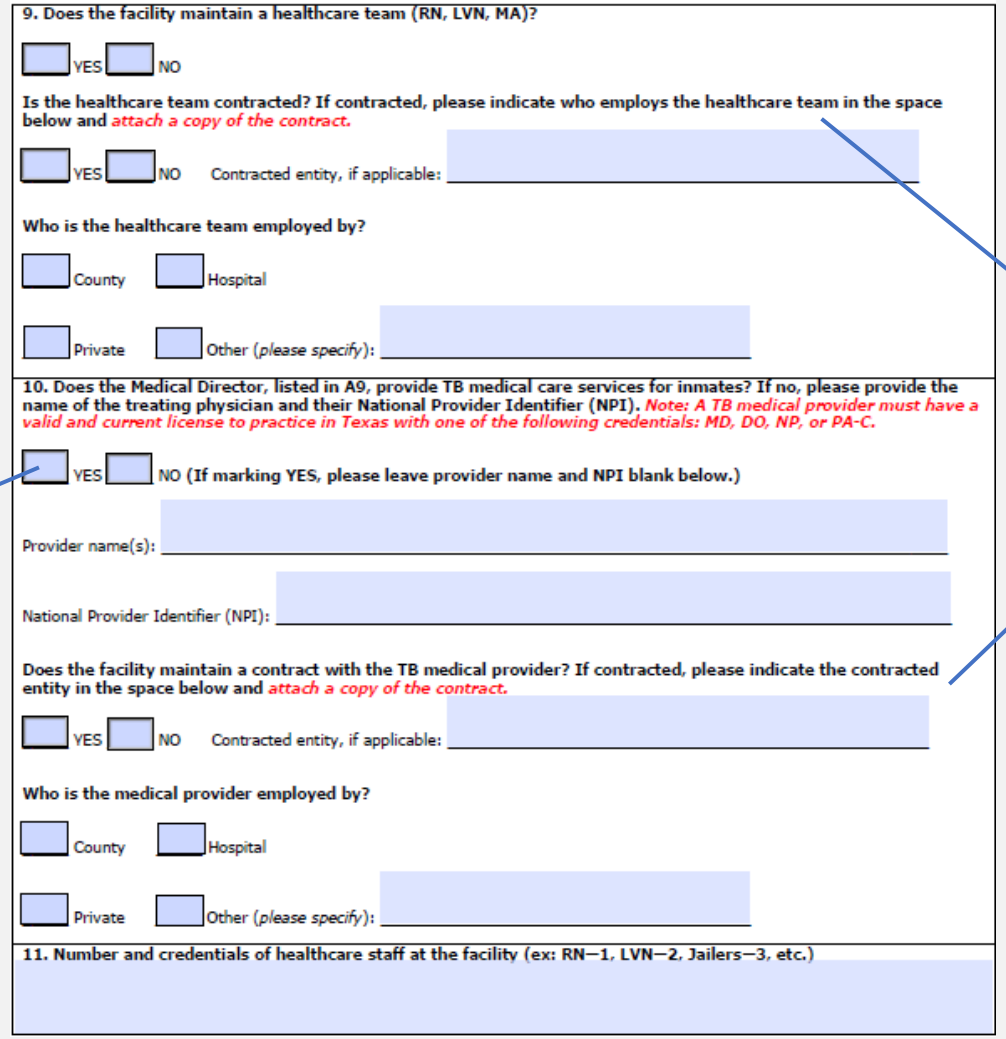
Section B. Facility Information (continued)



9. Does the facility maintain a healthcare team (RN, LVN, MA)?

☐ YES ☐ NO

Is the healthcare team contracted? If contracted, please indicate who employs the healthcare team in the space below and *attach a copy of the contract.*

☐ YES ☐ NO Contracted entity, if applicable: _____

Who is the healthcare team employed by?

☐ County ☐ Hospital

☐ Private ☐ Other (*please specify*): _____

10. Does the Medical Director, listed in A9, provide TB medical care services for inmates? If no, please provide the name of the treating physician and their National Provider Identifier (NPI). *Note: A TB medical provider must have a valid and current license to practice in Texas with one of the following credentials: MD, DO, NP, or PA-C.*

☐ YES ☐ NO **(If marking YES, please leave provider name and NPI blank below.)**

Provider name(s): _____

National Provider Identifier (NPI): _____

Does the facility maintain a contract with the TB medical provider? If contracted, please indicate the contracted entity in the space below and *attach a copy of the contract.*

☐ YES ☐ NO Contracted entity, if applicable: _____

Who is the medical provider employed by?

☐ County ☐ Hospital

☐ Private ☐ Other (*please specify*): _____

11. Number and credentials of healthcare staff at the facility (ex: RN—1, LVN—2, Jailers—3, etc.)

If the medical director listed in A9 ***does*** provide TB care for inmates, check YES and leave provider name and NPI blank.

Ensure that medical contracts are **attached to the screening plan**.

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Sample Contracts

Automatic Renewal

ARTICLE VI: TERM AND TERMINATION OF AGREEMENT

6.1 Term. This Agreement shall commence on October 1, 2021. The initial term of this Agreement shall end on September 30, 2022, and this Agreement shall thereafter be automatically extended for additional periods of twelve months each, beginning on October 1 of each year, subject to County funding availability, unless either party provides written notice to the other of its intent to terminate, or non-renew, in accordance with the provisions of Section No. 6.2 of this Agreement.

Expires Mid-Year

Contract Period: October 1, 2022, through September 30, 2023	
Base annualized fee:	$221,335.92 ($18,444.66 per month)
Per diem greater than 130 inmates:	$1.57
Annual outside cost pool limit:	$40,000.00 (includes 100% pool refund provision)

Section B. Facility Information (continued)

12. Number and credentials of healthcare staff trained on TB symptom screening (ex: RN—1, LVN—2, Jailers—3, etc.)

13. List names and credentials of all staff the medical director or TB medical provider has authorized to administer, read, and interpret the TB skin test. ***(Attach a separate sheet if necessary).***

14. Types of TB tests performed at your facility ***(Select all that apply)***

- ☐ QuantiFERON-TB Gold (QFT)
- ☐ T-SPOT
- ☐ Tuberculin Skin Test (TST)

15. If your facility uses a blood test (QFT and/or T-SPOT) to screen for TB, please answer the questions below. Please indicate N/A if your facility only uses TST to screen.

Please specify who provides the QFT and/or T-SPOT to your facility (e.g., Quest Diagnostics)?

In what instances is the blood test used (e.g., confirmatory testing, testing of refusals, etc.)?

16. Are chest x-rays performed at the facility?

☐ YES ☐ NO

Please provide the information of the chest x-ray provider:

Name (provider of x-rays):

Phone Number:

Address:

17. Are chest x-rays interpreted by the same x-ray facility listed in question 16? If NO, please provide the information below?

☐ YES ☐ NO **(If marking YES, please skip the rest of this question.)**

Name (provider of x-rays):

Phone Number:

Address:

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 or are suspected to be due to tuberculosis disease.
http://statutes.capitol.texas.gov/Docs/HS/htm/HS.89.htm

18. In the event of a hurricane or other natural or man-made disaster, do you have a written evacuation plan on file?

☐ YES ☐ NO

Will you relocate? If YES, please specify the location you will relocate to.

☐ YES ☐ NO Location:

If facility only uses TST, please indicate N/A in **both** spaces.

Reminder: *Your local or regional health department cannot provide state-purchased blood tests to your facility.*

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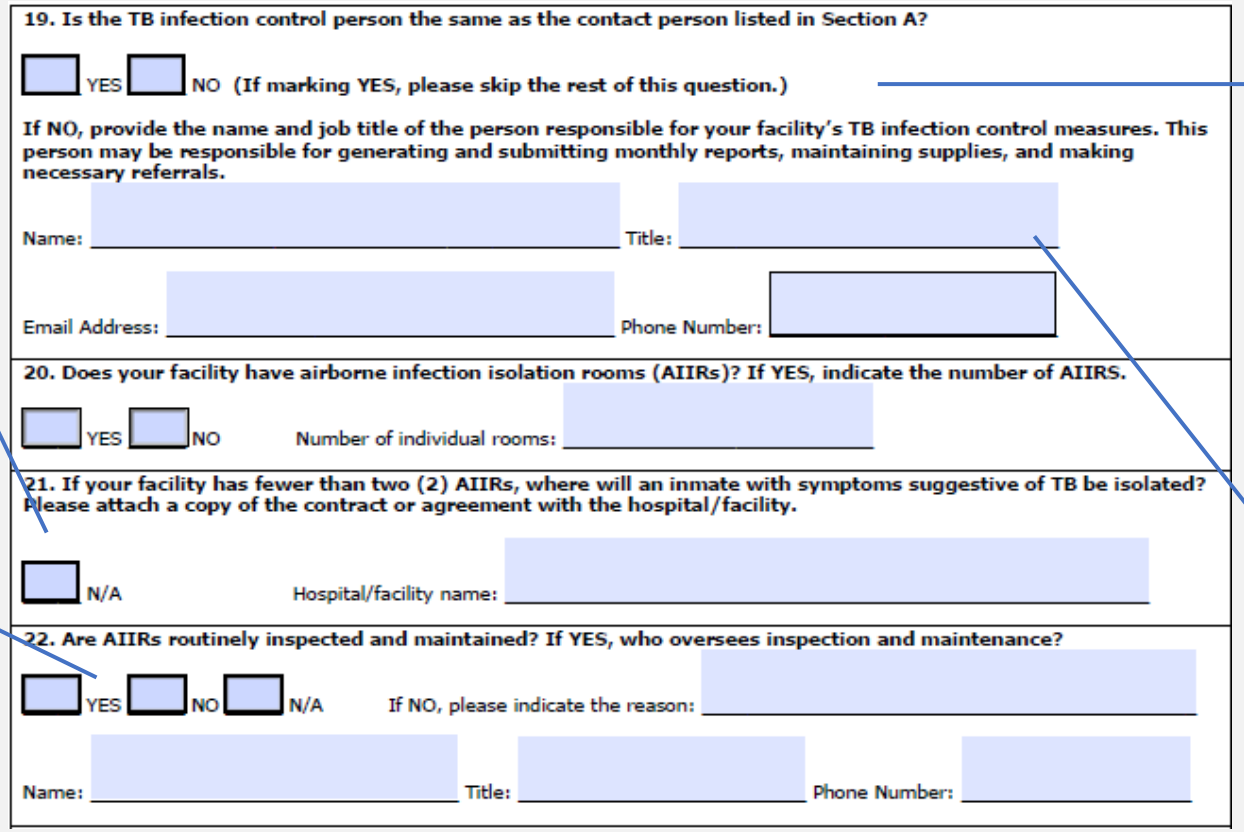
Section B. Facility Information (continued)

If facility has fewer than 2 AIIRs, please attach a copy of the contract or agreement with the hospital/facility where inmate will be isolated.

If facility does not have AIIRs, please check N/A.



19. Is the TB infection control person the same as the contact person listed in Section A?

☐ YES ☐ NO (If marking YES, please skip the rest of this question.)

If NO, provide the name and job title of the person responsible for your facility's TB infection control measures. This person may be responsible for generating and submitting monthly reports, maintaining supplies, and making necessary referrals.

Name: _____ Title: _____

Email Address: _____ Phone Number: _____

20. Does your facility have airborne infection isolation rooms (AIIRs)? If YES, indicate the number of AIIRS.

☐ YES ☐ NO Number of individual rooms: _____

21. If your facility has fewer than two (2) AIIRs, where will an inmate with symptoms suggestive of TB be isolated? Please attach a copy of the contract or agreement with the hospital/facility.

☐ N/A Hospital/facility name: _____

22. Are AIIRs routinely inspected and maintained? If YES, who oversees inspection and maintenance?

☐ YES ☐ NO ☐ N/A If NO, please indicate the reason: _____

Name: _____ Title: _____ Phone Number: _____

Language update: If marking YES, please skip the rest of this question.

Please do not use any abbreviations or acronyms for titles.

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Section B. Facility Information (continued)

23. Which of the following actions does your facility take in the event a suspected or confirmed TB case is identified? Please see the screening algorithm for incarcerated individuals for reference. Please check all that apply.

- ☐ Immediately isolate the individual in an AIIR or send them to the hospital for isolation
- ☐ Perform chest x-ray within 72 hours
- ☐ Order acid-fast bacilli (AFB) testing on sputum smear/culture within 72 hours
- ☐ Ensure thorough medical evaluation
- ☐ Provide surgical mask to the inmate and ensure staff/personnel wear N-95 or equivalent
- ☐ Other (*Specify*): _____
- ☐ Report to the local or regional health department within one working day
- ☐ Order a Nucleic Acid Amplification Test (NAAT) (i.e., rapid PCR)
- ☐ Provide treatment for TB
- ☐ Conduct a Contact Investigation (CI)
- ☐ Perform TST for symptomatic inmates

Reminder for health departments: *Please ensure that the infection control measures checked in this question are in alignment with the facility's practices.*

Section B. Facility Information (continued)

Be sure to add the contact person's title.

Ensure the listed contact persons are accurate. Reach out to your health department if needed!

24. Provide name, mailing address, and phone number of local or regional health department (who your facility reports to) and the name of the contact person(s). You may list up to two individuals.

Health department name:

Name:

Title:

Phone Number:

Email Address:

Address:

Name:

Title:

Phone Number:

Email Address:

Address:

25. What is the name and title of the person at your facility who informs the local or regional health department about TB suspects and/or cases in custody? You may list up to two individuals.

Name:

Title:

Phone Number:

Email Address:

Name:

Title:

Phone Number:

Email Address:

26. Who supplies purified protein derivatives (PPDs) for inmate TB testing at your facility?

☐ Pharmacy (*Specify name and address*)

☐ Health Department (*Specify full name and address*)

☐ Other (*Specify name and address*)

27. Who supplies syringes for inmate TB testing at your facility?

☐ Pharmacy (*Specify name and address*)

☐ Health Department (*Specify full name and address*)

☐ Other (*Specify name and address*)

Please ensure full spelling of the health department, if applicable.

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Section B. Facility Information (continued)

28. Who supplies your facility with TB medications? Please provide the name and address of the entity. Do not use acronyms or abbreviations.

Name: _____

Address: _____

29. What other TB services does your local or regional health department provide to your facility?

- ☐ None
- ☐ Education and/or Training
- ☐ TB Testing at Intake
- ☐ Contact Investigation
- ☐ TB Annual Screenings
- ☐ TB Medication
- ☐ Other (*Specify*): _____

Please list the pharmacy or entity that you obtain TB medications from.

***Reminder**: DSHS-purchased medications cannot be distributed to jails unless the health department serves as the TB medical provider.*

Ensure services checked are in alignment with services provided by the TB program.

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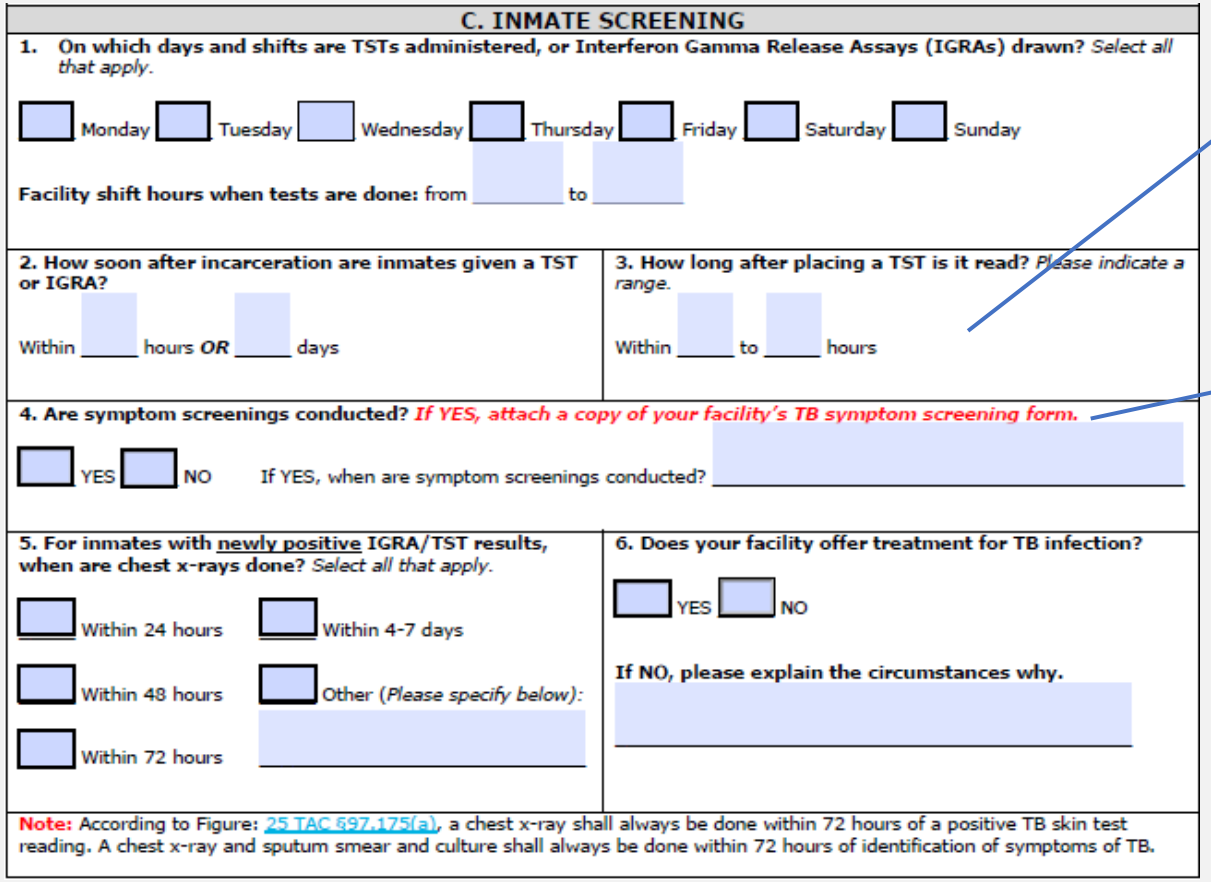
Section C. Inmate Screening

Section C. Inmate Screening



C. INMATE SCREENING

1. **On which days and shifts are TSTs administered, or Interferon Gamma Release Assays (IGRAs) drawn?** *Select all that apply.*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Facility shift hours when tests are done: from _____ to _____

2. **How soon after incarceration are inmates given a TST or IGRA?**

Within _____ hours ***OR*** _____ days

3. **How long after placing a TST is it read?** *Please indicate a range.*

Within _____ to _____ hours

4. **Are symptom screenings conducted?** ***If YES, attach a copy of your facility's TB symptom screening form.***

☐ YES ☐ NO If YES, when are symptom screenings conducted? _____

5. **For inmates with newly positive IGRA/TST results, when are chest x-rays done?** *Select all that apply.*

☐ Within 24 hours ☐ Within 4-7 days

☐ Within 48 hours ☐ Other (*Please specify below):*

☐ Within 72 hours _____

6. **Does your facility offer treatment for TB infection?**

☐ YES ☐ NO

If NO, please explain the circumstances why.

_____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

Ensure that TSTs are read 48 to 72 hours after placement.

Ensure that if YES is selected that it is specified when symptom screenings are performed AND the symptom screening form is attached.

***Note**: The TB symptom screening form must be specific to TB or include TB-specific symptoms.*

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Section C. Inmate Screening (continued)

7. When do annual screenings of long-term inmates take place?

☐ 12 months after the last test

☐ On a designated month (*Please specify*): _____

☐ Other (*Please specify*): _____

8. Do you have a written continuity of care plan for inmates diagnosed or suspected with TB scheduled for release into the community or transferred? *If YES, please attach a copy of the plan.*

☐ YES ☐ NO

9. Who maintains inmate screening records?

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

10. Who is responsible for sending transfer records to Texas Department of Criminal Justice (TDCJ) or other correctional facilities on inmates with TB infection or suspected/confirmed TB disease?

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

11. Who is responsible for notifying the local or regional health department when an inmate with TB infection or suspected/confirmed TB disease is transferred or released?

Name: _____ Title: _____

Phone Number: _____ Email Address: _____

Note: All inmates shall be evaluated for TB infection and disease. All treatment must be documented. A record of treatment (TB-400A 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 TB-400A, TB-400B, and other forms are available at dshs.texas.gov/disease/tb/forms.shtm.

12. Which form(s) are used to transfer inmate records? *Select all that apply.* ***Please attach a copy of the form(s).***

☐ Texas Uniform Health Status Update ☐ Prisoner in Transit Medical Summary Form (USM-553)

☐ Other (*Please specify*): _____

Ensure that the continuity of care plan is attached.

Remember to attach these forms!

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Examples of Continuity of Care Plans

All new inmates who are processed into the jail, who are on treatment and deemed not infectious will be housed in general population. If a patient is released from Jail during therapy, the local Health Department will be notified and provided with the patient's release location and/or the patient's last known address.

Transfers/Release

1. Inmate-patients with active TB are not transferred to other correctional facilities without prior notification and planning. All transfers include copies of transfer sheets identifying TB status and medication usage sent with them.

   A. When an inmate-patient on LTBI treatment is transferred to an outside facility before completion of TB treatment, notification is made to the receiving correctional facility of the inmate-patient's current TB medication and requirements for completion of therapy.

   B. A copy of an inmate-patient's medical records or documentation of screenings or treatment received during confinement accompanies an inmate transferred from a correctional facility to another and is available for medical review upon arrival of the inmate.

When an inmate-patient has been diagnosed with active TB or LTBI and upon notification of an inmate-patient's pending release before completion the following occurs:

a. When an inmate-patient on LTBI treatment is released before completion of TB therapy, the inmate-patient is provided a prescription for a month's supply of INH tablets with instructions to take 1 tablet (300mg INH) a day.
b. A review of the medication record confirms current prescribed medications.
c. The inmate-patient is provided with any medication requirements as deemed necessary per order by a responsible physician or designee. All discharge medications must be clearly documented in the medical record including release, medication type and amount, and name of receiving pharmacy.
d. When an inmate-patient is non-insured, medication requirements are called into the back-up pharmacy.
e. When an inmate-patient has insurance, medication requirements are called into the pharmacy of their choice.
f. The facility administrator or designee arranges transportation to a community provider.
g. The inmate-patient is also provided the name and address of the health department where treatment can be obtained.
h. The inmate-patient is counseled to seek medical consultation as clinically indicated and to seek prompt medical attention if signs or symptoms are clinically indicated.

Section D. Employee Screening

Section D. Employee Screening

D. EMPLOYEE SCREENING

1. Does your facility perform initial employee screenings?

☐ YES ☐ NO

If YES, when do initial screenings take place?

☐ Prior to employment

☐ Within 7 days of starting

☐ Other (*Please specify):* _____

2. Does your facility perform annual employee screenings?

☐ YES ☐ NO

If YES, when do annual screenings take place?

☐ 12 months from date of hire

☐ On a designated month (Please specify): _____

☐ Other (*Please specify):* _____

If you check YES, please specify when screenings take place.

3. Are employee screenings performed onsite or through referral?

☐ Onsite at facility ☐ Referral (*Please specify):* _____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

4. If an employee has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The employee must provide a physician certification indicating "no active disease" before returning to work.

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

5. Who is responsible for keeping employee certification records?

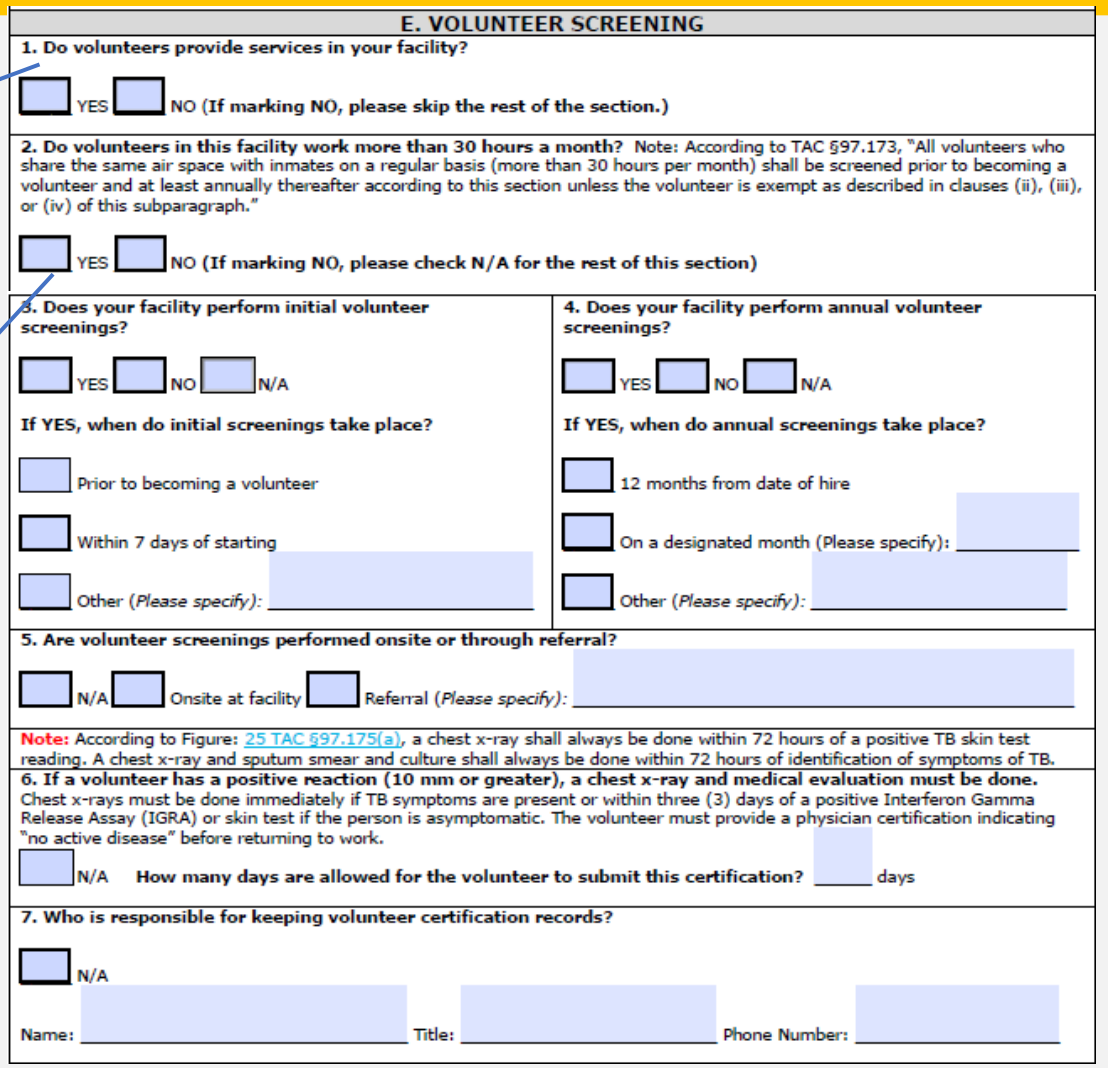
Name: _____ Title: _____ Phone Number: _____

Section E. Volunteer Screening

Section E. Volunteer Screening

If volunteers do not provide services, please mark NO and skip the rest of the section.

NEW: If volunteers do not work more than 30 hours a month, please mark N/A for the rest of the section.



E. VOLUNTEER SCREENING

1. Do volunteers provide services in your facility?

☐ YES ☐ NO **(If marking NO, please skip the rest of the section.)**

2. Do volunteers in this facility work more than 30 hours a month? Note: According to TAC §97.173, "All volunteers who share the same air space with inmates on a regular basis (more than 30 hours per month) shall be screened prior to becoming a volunteer and at least annually thereafter according to this section unless the volunteer is exempt as described in clauses (ii), (iii), or (iv) of this subparagraph."

☐ YES ☐ NO **(If marking NO, please check N/A for the rest of this section)**

3. Does your facility perform initial volunteer screenings?

☐ YES ☐ NO ☐ N/A

If YES, when do initial screenings take place?

☐ Prior to becoming a volunteer

☐ Within 7 days of starting

☐ Other (*Please specify*): _____

4. Does your facility perform annual volunteer screenings?

☐ YES ☐ NO ☐ N/A

If YES, when do annual screenings take place?

☐ 12 months from date of hire

☐ On a designated month (Please specify): _____

☐ Other (*Please specify*): _____

5. Are volunteer screenings performed onsite or through referral?

☐ N/A ☐ Onsite at facility ☐ Referral (*Please specify*): _____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

6. If a volunteer has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The volunteer must provide a physician certification indicating "no active disease" before returning to work.

☐ N/A **How many days are allowed for the volunteer to submit this certification?** _____ days

7. Who is responsible for keeping volunteer certification records?

☐ N/A

Name: _____ Title: _____ Phone Number: _____

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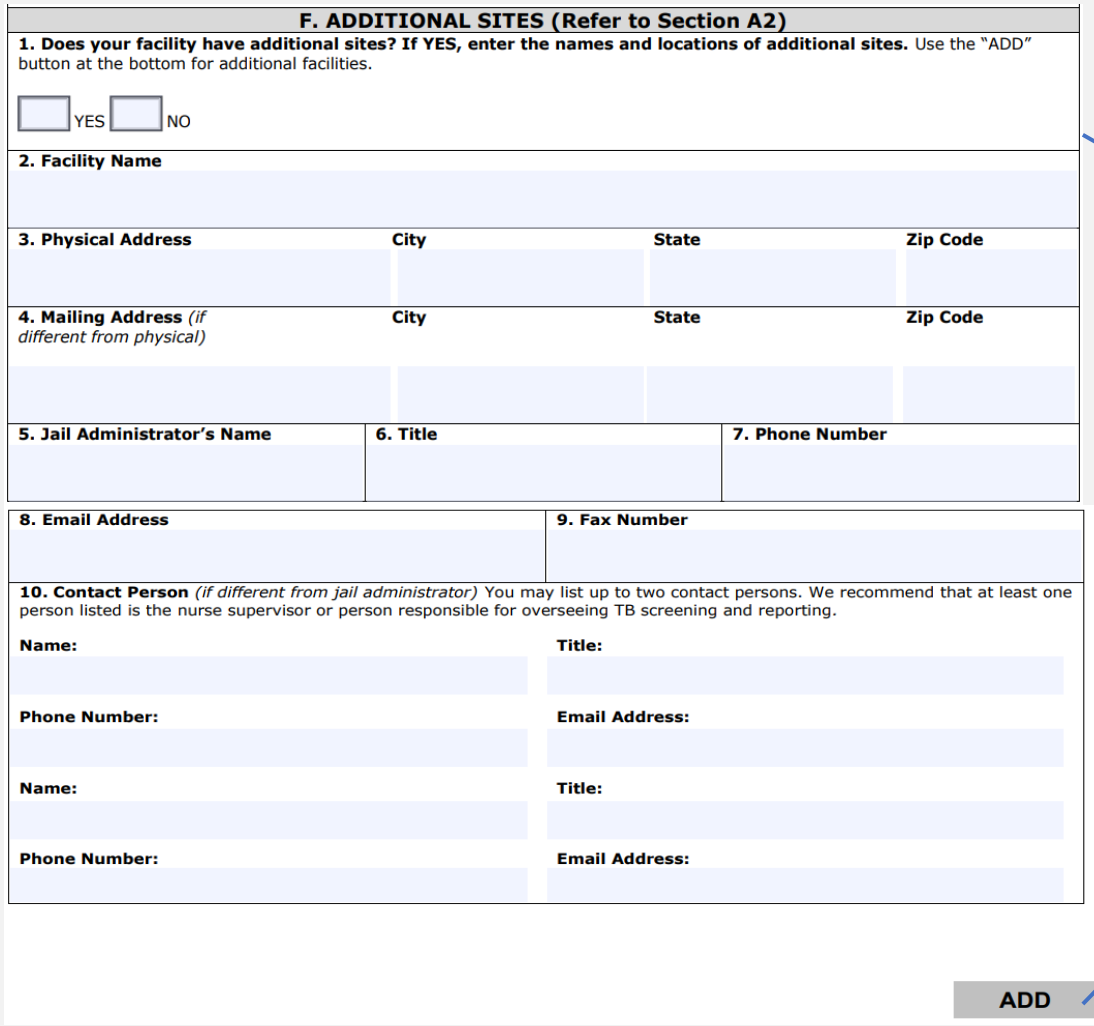
Section F. Additional Sites

Section F. Additional Sites



F. ADDITIONAL SITES (Refer to Section A2)

1. Does your facility have additional sites? If YES, enter the names and locations of additional sites. Use the "ADD" button at the bottom for additional facilities.

☐ YES ☐ NO

2. Facility Name

3. Physical Address	**City**	**State**	**Zip Code**

4. Mailing Address *(if different from physical)*	**City**	**State**	**Zip Code**

5. Jail Administrator's Name	**6. Title**	**7. Phone Number**

8. Email Address	**9. Fax Number**

10. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.

Name:	**Title:**
Phone Number:	**Email Address:**
Name:	**Title:**
Phone Number:	**Email Address:**

ADD

Add information on additional sites.

Use the ADD button to add more than one additional site.

TEXAS Health and Human Services

Texas Department of State Health Services

Section G. Plan Submission and Acknowledgement

Section G. Plan Submission and Acknowledgement

G. PLAN SUBMISSION AND ACKNOWLEDGEMENT

Submission type (*select one*)

☐ ANNUAL PLAN

☐ AMENDED PLAN (*Please specify date of original submission*): _____

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 and the form is accurate and complete to the best of my knowledge. By printing your name below, you acknowledge and agree that it serves as your legal signature.

_____ _____

Jail Administrator Name Date

H. APPROVAL

Email the signed original plan to Texas Department of State Health Services, Tuberculosis and Hansen's Disease Unit, at CongregateSettings@dshs.texas.gov where the plan, once approved, will be maintained.

If any sections are left blank, are answered incorrectly, or required supporting documentation is missing, the form will be returned with requested revisions.

Texas Department of State Health Services Tuberculosis and Hansen's Disease Unit

dshs.texas.gov/tuberculosis-tb/tb-prevention-care-correctional

NEW: Jail administrator's printed/typed name serves as the legal signature of this document.

*Amended plans are needed when there are administrative or operational changes that negate the information on the approved screening plan. Amended screening plans require resubmission of **all** pages and an updated jail administrator signature and date.*

TEXAS Health and Human Services

Texas Department of State Health Services

TB-805 Checklist

TB-805 Checklist for Jails

- **Both jails AND health departments are required to fully complete their respective TB-805 Checklists.**
- Sign and date the checklist after completion and send it to your local or regional health department with your screening plan
- **NOTE:** There are two checklists available on the website:
  - TB-805A (Checklist A for health departments)
  - TB-805B (Checklist B for jails)

https://www.dshs.texas.gov/tuberculosis-tb

TEXAS Health and Human Services
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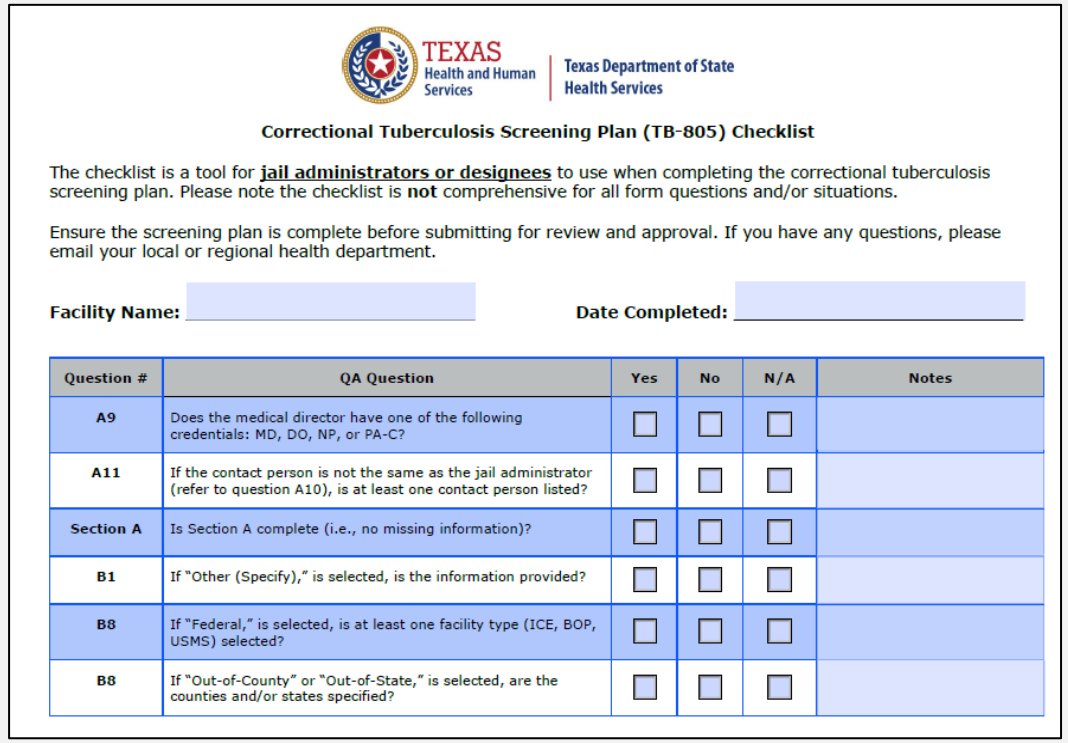

TEXAS Health and Human Services | Texas Department of State Health Services

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?	☐	☐	☐	

TB-805A	Correctional TB Screening Plan - Checklist (for health departments)	8/2024
TB-805B	Correctional TB Screening Plan - Checklist (for jails)	8/2024

Knowledge Check

Knowledge Check: Question 1

Credential is not MD, DO, NP, or PA-C

Street address is not provided

9. Medical Director (MD, DO, NP, or PA-C)

Name	Credentials (MD, DO, NP, or PA-C)	
June Smith	LVN	
National Provider Identifier (NPI)	**Email Address**	
N/A	June.Smith@TexasCountyJail.gov	
Phone Number	**Address**	
(512) 369-2247		
City	**State**	**Zip Code**
Austin	Texas	78552

Section B, Question #10

Knowledge Check: Question 2

Re-entered provider name and NPI

10. Does the Medical Director, listed in A9, provide TB medical care services for inmates? If no, please provide the name of the treating physician and their National Provider Identifier (NPI). ***Note: A TB medical provider must have a valid and current license to practice in Texas with one of the following credentials: MD, DO, NP, or PA-C.***

☒ YES ☐ NO **(If marking YES, please leave provider name and NPI blank below.)**

Provider name(s): Dr. Jane Doe

National Provider Identifier (NPI): 1234567890

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Texas Department of State Health Services

Knowledge Check: Question 3

Did not check the categories of inmates

8. Which category of inmate is the facility authorized to hold? ***(Select all that apply)***

☒ Federal (*Select all that apply*): ☐ Immigration and Customs Enforcement ☐ Bureau of Prisons ☐ U.S. Marshals

☒ County

☒ Out-of-County *(Please list the counties that you have a contract, memorandum of agreement (MOA), or memorandum of understanding (MOU) with):*

Garza, Trinity, Gonzales, Presidio, Van Zandt

☐ Out-of-State *(Please list the states that you have a contract, memorandum of agreement (MOA), and/or memorandum of understanding (MOU) with):*

Section B, Question #9

Knowledge Check: Question 4

Did not specify whom the health care team is contracted by

9. Does the facility maintain a health care team (RN, LVN, MA)?

☒ YES ☐ NO

Is the health care team contracted? If contracted, please indicate who employs the health care team in the space below and *attach a copy of the contract.*

☒ YES ☐ NO Contracted entity, if applicable: _____

Who is the health care team employed by?

☐ County ☐ Hospital

☒ Private ☐ Other (*please specify*): _____

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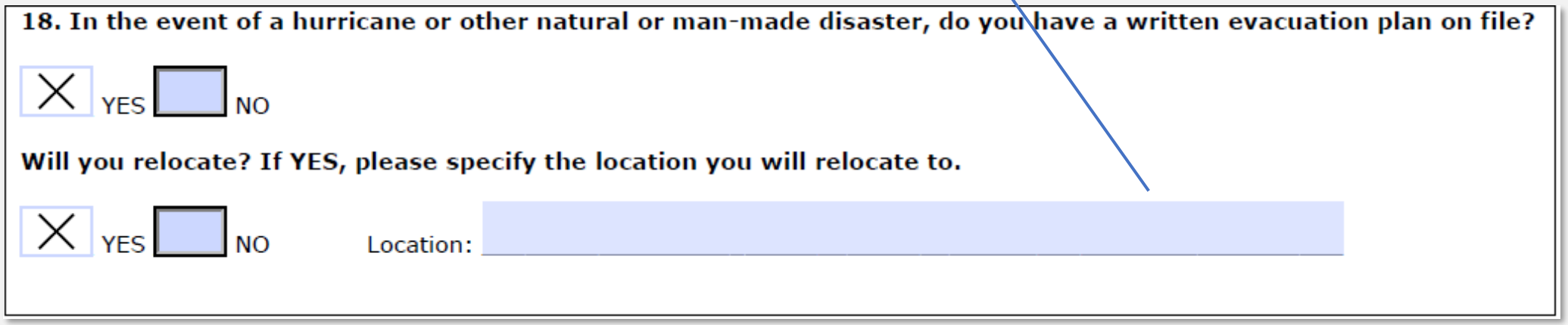
Texas Department of State Health Services

Section B, Question #18

Knowledge Check: Question 5

Did not specify the location


18. In the event of a hurricane or other natural or man-made disaster, do you have a written evacuation plan on file?

X YES ☐ NO

Will you relocate? If YES, please specify the location you will relocate to.

X YES ☐ NO Location:

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Section B, Question #19

Knowledge Check: Question 6

Re-entered contact person's information

19. Is the TB infection control person the same as the contact person listed in Section A?

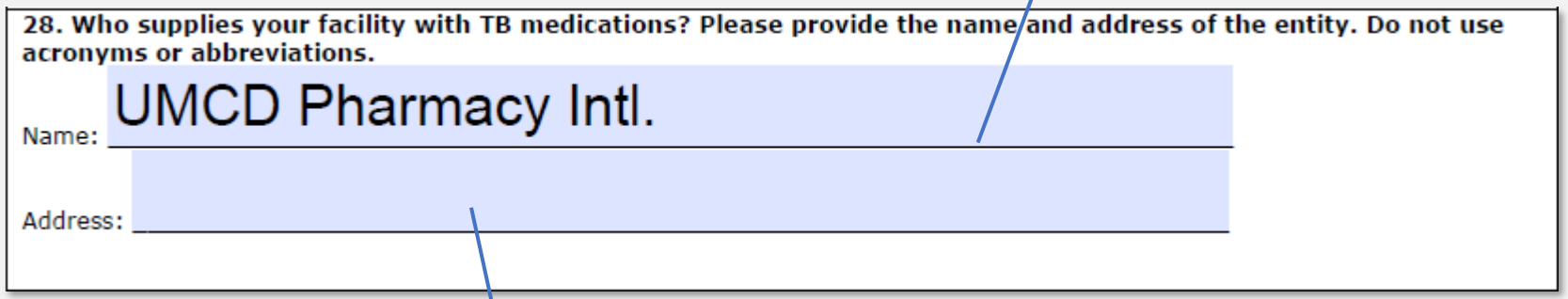
X YES ☐ NO (If marking YES, please skip the rest of this question.)

If NO, provide the name and job title of the person responsible for your facility's TB infection control measures. This person may be responsible for generating and submitting monthly reports, maintaining supplies, and making necessary referrals.

Name: John Smith Title: Captain

Email Address: johnsmith@email.com Phone Number: 123-456-7890

Knowledge Check: Question 7



Used an unknown acronym and abbreviation

Did not provide the pharmacy's address

Knowledge Check: Question 8

Did not specify the month

D. EMPLOYEE SCREENING

1. Does your facility perform initial employee screenings?	2. Does your facility perform annual employee screenings?
[X] YES [ ] NO	[X] YES [ ] NO
If YES, when do initial screenings take place?	**If YES, when do annual screenings take place?**
[ ] Prior to employment	[ ] 12 months from date of hire
[X] Within 7 days of starting	[X] On a designated month (Please specify):
[ ] Other (*Please specify*):	[ ] Other (*Please specify*):

General Guidance

Do not leave any applicable questions blank.

Do not use any acronyms or abbreviations (unless they are preapproved abbreviations or acronyms).

Ensure you submit clean and legible copies of all documents electronically.

Complete, sign, date, and submit the checklist with your screening plan.

Electronically re-sign and date the last page of the screening plan when re-submitting your screening plan with revisions.

***NEW**: The TB-805 will only be accepted if it is completed and signed electronically. Copies that have been manually filled out and signed will not be accepted.*

Acceptable Acronyms

- Doctor of Medicine: **MD**
- Doctor of Osteopathic Medicine: **DO**
- Nurse Practitioner/Family Nurse Practitioner: **NP/FNP/FNP-C**
- Physician Assistant- Certified: **PA-C**
- Registered Nurse: **RN**
- Licensed Vocational Nurse: **LVN**
- Emergency Medical Technician: **EMT**
- Advanced Emergency Medical Technician: **AEMT**
- Certified Nursing Assistant: **CNA**
- Certified Medical Assistant: **CMA**

For all other acronyms please spell out the full word on each use, or spell it out on the first use and provide the acronym in parentheses. It is then acceptable to use the acronym in subsequent answers.
Example: Certified Clinical Medical Assistant (CCMA)

Supporting Documents (as applicable)

- Health care team provider contract (Question B9)
- Medical provider contract (Question B10)
- Names and credentials of additional staff authorized to perform TB skin tests (Question B13)
- Contract or agreement with hospital/facility where AIIRs are used (Question B21)
- Facility's TB symptom screening form (Question C4)
- Facility's continuity of care plan (Question C8)
- Form(s) used to transfer inmate records (Question C12)
- TB-805 Checklist

Helpful Tips

- Use the TB-805 checklist to assist in your review of the screening plan
- Jail administrators: Communicate with your local or regional health department's TB Program point of contact for questions regarding TB activities
- TB Programs: Communicate with jail administrators/points of contact for revisions or missing information/documents
- Submit the plan at least **60 days** before expiration to ensure timely review and approval
- TB Programs: Your assigned Program Evaluation Consultant (PEC) is ready to assist if you need additional help!

Questions?

Correctional TB Training:
Correctional Tuberculosis Screening Plan (TB-805)

cqiteam@dshs.texas.gov

texastb.org

Thank you!

Correctional TB Training:
Correctional Tuberculosis Screening Plan (TB-805)

cqiteam@dshs.texas.gov

texastb.org