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

Correctional Tuberculosis Screening Plan (TB-805) Checklist B

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.

Please submit your signed checklist and completed screening plan to your local program for review. 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 point of contact is not the same as the jail administrator (refer to question A10), is at least one point of contact 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 9/2023; Revised 8/2026

Question #	QA Question	Yes	No	N/A	Notes
B9B	Is a copy of the **current** contract for the healthcare team attached? **Note**: Current contracts are active through the approval period, i.e., 2027, or automatically renewed.	☐	☐	☐	
B10	Are the remaining questions completed if the medical provider is the same as in question A9?	☐	☐	☐	
B10B	Is a copy of the **current** contract for the medical provider attached? **Note**: Current contracts are active through the approval period, i.e., 2027, 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	Is the information for the person responsible for the facility's TB infection control measures completed?	☐	☐	☐	
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?	☐	☐	☐	
B23	If applicable, was a date provided for the last AIIR(s) inspection?	☐	☐	☐	
B25	Is the correct contact person(s) listed? Contact the health department to verify this information.	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
B27 and B28	If the health department provides testing supplies, is it reflected accurately? Ensure the full spelling of the health department.	☐	☐	☐	
B27 and B28	Is the full name and address of the supplying entity provided?	☐	☐	☐	
B27 and B28	Were instances where the secondary supplier would be used listed?	☐	☐	☐	
B29	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.	☐	☐	☐	
B30	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?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
C4	If symptom screenings are conducted, is it specified when they are performed?	☐	☐	☐	
C4	Is a copy of the TB symptom screening form attached? **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.	☐	☐	☐	
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?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
Section D	Is Section D complete (i.e., no missing information)?	☐	☐	☐	
E1	If "NO" is selected, is the rest of the section skipped?	☐	☐	☐	
E2	If "NO" is selected, is the rest of the section skipped?	☐	☐	☐	
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?	☐	☐	☐	
F1	If "NO" is selected, is the rest of the section skipped?	☐	☐	☐	
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 healthcare team provider contract (question B9)	☐	☐	☐	
Current medical service provider contract (question B10)	☐	☐	☐	
Staff and their credentials (question B13)	☐	☐	☐	
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: _____