



Correctional Tuberculosis Screening Plan (TB-805) Checklist

The checklist is a tool for first-line reviewers (local and regional TB programs) to perform quality assurance for correctional tuberculosis screening plans on commonly missed items. Please note that the checklist is not comprehensive for all form questions and/or situations.

Ensure that the screening plan is complete before submitting it to Central Office. If you have any questions, email cqiteam@dshs.texas.gov.

Facility Name: _____ Date Reviewed: _____

Table with 6 columns: Question #, Question, Yes, No, N/A, Notes. Rows include questions A9, A11, Section A, B1, B8, B8, and B9 regarding medical director credentials, contact persons, and facility types.



Question #	Question	Yes	No	N/A	Notes
B10	Did the facility complete the remaining questions if the medical provider is the same as in question A9?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B10	Did the facility attach a current contract for the medical provider? Note: Current contracts are active through the approval period, i.e., 2024, or automatically renewed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B13	If needed, was a separate sheet with the names and credentials attached?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B14	Does the facility perform QFTs and/or T-SPOTs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B15	If the question above is marked "YES," did the facility list the entity providing the QFT/T-SPOT supplies? Note: TB Programs cannot use DSHS-funded services (e.g., Quest) to provide IGRA testing for Chapter 89-designated facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B15	If the facility uses a TST and an IGRA, do the instances align with DSHS standards (i.e., no confirmatory testing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B16	Did the facility provide information on the CXR provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B17	If "NO" is selected, did the facility fill out ALL the appropriate information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B18	If the facility will relocate, was the location specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B19	If the TB infection control person is NOT the same as the contact person in Section A, was the appropriate information filled out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	Question	Yes	No	N/A	Notes
B20	If the facility has AIIRs, did they indicate the number of AIIRs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B21	If the facility has fewer than two AIIRs, did they specify where they will isolate inmates?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B22	If "YES" is selected, did the facility provide the information on who oversees inspection and maintenance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B22	If "NO" is selected, did the facility indicate the reason for not routinely inspecting and maintaining AIIRs at the facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B26 and B27	If the health department provides testing supplies, is it reflected accurately? Ensure the full spelling of the health department.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B26 and B27	Did the facility provide both the name and address of the supplying entity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B28	Did the facility list an entity that is not the health department?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B29	Are the services checked consistent with what is provided by the local or regional TB Program? Ensure alignment with your TB program's services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section B	Is Section B complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C1	Did the facility include AM or PM for the facility shift hours if not using a 24-hour format?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C3	Did the facility note that TSTs read within 48-72 hours of placement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C4	If symptom screenings are conducted, did the facility specify when they are performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	Question	Yes	No	N/A	Notes
C4	Did the facility attach a copy of the TB symptom screening form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C6	If the facility does NOT offer treatment for TB infection, did the facility explain why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C7	If "On a designated month" is selected, did the facility list the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C7	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C8	Did the facility attach a copy of the continuity of care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C12	Did the facility attach all applicable transfer forms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section C	Is Section C complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D1	If "Other" is selected, did the facility specify when initial screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D2	If "On a designated month" is selected, did the facility specify the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D2	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section D	Is Section D complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E3	If "Other" is selected, did the facility specify when initial screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E4	If "On a designated month" is selected, did the facility specify the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E4	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	Question	Yes	No	N/A	Notes
Section E	Is Section E complete (no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
F1	If the facility selected "YES," did they provide the appropriate information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section G	Did the facility check the submission type?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
END PAGE	Did the jail administrator sign and date the plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	