

Date: ___/___/_____



What is Jana's Place

Jana's Place is a 15-bed residential treatment program for female survivors of commercial sexual exploitation with co-occurring SUD and moderate to severe mental health disorders.

Our treatment model is unique as it does not treat SUD or MHD in a vacuum. Instead our approach is holistic and comprehensive with survivor-led programming and participant-centered recovery plans. Additionally, Jana's Place assists participants in achieving long-term recovery through programming that works to reduce several barriers that participants may face after their time at Jana's Place. Barriers to gainful employment, housing, and health care are addressed by providing job-skills training, professional and life-skills development, and onsite medical care facilities. Jana's Place is where survivors will begin to heal, feel empowered to participate in their recovery, and build the social connections and support systems critical to long-term recovery.

What to complete for a referral?

- The attached referral form
- A biopsychosocial that has been completed within the last 30 days

What happens next:

- Somebody will reach out within 72 hours to discuss next steps and a more detailed program overview



Date: ___/___/_____



Living In Freedom Together (LIFT)

Jana's Place Referral Form

Please complete and return this form to LIFT with a current biospsychsocial at:

Mail: Living in Freedom Together 34 Cedar Street #301 Worcester MA 01609

Fax: (774-642-6572)

If you have additional questions or concerns, please call 508-471-5868

Demographic Information for Participant

Full Name: _____ Last Name _____ First Name _____ **DOB:** ___/___/_____

Address: _____ Homeless

Gender Identity: _____ **Sexual Orientation:** _____

Pronouns: She/her/hers He/him/his They/them/theirs Zie/zir/zirs Other: _____

Race: White Black Hispanic/Latinx Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native
 Other: _____

Ethnicity: _____ **Primary Language:** _____ **Preferred Language:** _____

Phone #: _____ Safe to call Safe to leave message Text only

Emergency Contact: _____ **Phone #:** _____
 Parent Sibling Friend Partner/SO Other: _____

=====
Marital Status: Single Relationship Married/Partnership Separated Divorced Widowed
 Other: _____

Source of Inc.: None Welfare/TANF SNAP EAEDC SSI/SSDI Prostitution
 Employment: _____ Other: _____

Highest Education: None K-12: _____ HS Diploma/GED Currently in school: _____
 College: _____ Certificate Program Other: _____

Insurance: _____ **Up to date?** Yes No

PCP: _____ **PCP/Provider Phone #:** _____

Referral Source

Referral Source:

Name: _____ Agency: _____

Primary Phone #: _____ Alternate Phone #: _____



Living in Freedom Together
Empowering and Elevating Survivors

Date: ___/___/_____

Address: _____

Has participant disclosed they are a victim of CSE? Yes No

Has the participant experienced any of the following in the past 3 months?

- An inpatient psychiatric hospitalization
- 2 ER visits or ESP visits
- Unsuccessful engagement and or inability to succeed in other community-based services based on psychosocial and clinical complexity relations to substance and or mental health disorders.

Indicate risk factors for CSE that the participant presents with:

- | | | |
|---|--|---|
| <input type="checkbox"/> DCF involvement | <input type="checkbox"/> Lack of valid identification | <input type="checkbox"/> Concerns about reproductive/sexual health (multiple STI's, pregnancies, abortions) |
| <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Severe mental health concerns | <input type="checkbox"/> Justice system involvement or criminal history |
| <input type="checkbox"/> Homelessness | <input type="checkbox"/> Physical signs of abuse (unexplained bruises, black eye, cuts, marks, etc.) | |
| <input type="checkbox"/> Signs of substance abuse | | |
| <input type="checkbox"/> History of abuse/trauma | | |

Why Jana's Place? And Why Now? :

Consent

I, _____, myself or legal guardian of _____, give consent to

Participant/Guardian Name

Participant Name

Living in Freedom Together to meet with and conduct an assessment with _____.

Participant Name

Printed Name of Participant / Guardian

Signature of Participant / Guardian

To set up INTAKE, please contact:

- Participant
- Referral source at _____
Contact Information