LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
TRANSITION AGE YOUTH SYSTEM OF CARE

Center for the Assessment and Prevention of Prodromal States

The Center for the Assessment and Prevention of Prodromal States **(CAPPS)** is an evidence-based treatment provided through Los Angeles County Department of Mental Health (LAC-DMH) Prevention and Early Intervention (PEI) Program. The **CAPPS** program provides family-focused treatment targeting adolescents and young adults, ages 16-25, at high risk for developing psychosis (prodromal phase) or experiencing their first psychotic break.

Services provided to the youth and their family includes: Comprehensive intake evaluation, Family Focused Therapy for Individuals at Clinical High Risk for Psychosis (FFT-CHR), psycho-education, communication enhancement, problem solving, and skill building. Also provided are Psychiatric Assessments, Medication Support, Case Management, and linkage to needed resources.

SERVICE DELIVERY SITES

Penny Lane (SA 1)
43520 Division Street
Lancaster, CA 93535
(661) 266-4783 x 2262

San Fernando Valley Community MHC (SA 2)
14535 Sherman Circle
Van Nuys, CA 91405
(818) 528-8887

The Help Group (SA 5)
Culver City, CA 90066
(310) 751-1174

Special Service for Groups – OTTP (SA 8)
19401 S. Vermont Avenue, Suite A200
Torrance, CA 90502
(310) 323-6887 x318

For more information about our CAPPS Program, please contact:

Sermed Alkass, PsyD, CAPPS Practice Lead
Transition Age Youth System of Care Bureau
salkass@dmh.lacounty.gov
(213) 738-4715

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
TRANSITION AGE YOUTH SYSTEM OF CARE

CENTER FOR THE ASSESSMENT AND PREVENTION OF PRODROMAL STATES

REFERRAL FORM

Consumer Information

LAST NAME: _____ FIRST NAME: _____
DOB:_____ SSN:_____ IS #:_____
ETHNICITY:_____ PREFERRED LANGUAGE(S):_____
GENDER ASSIGNED AT BIRTH:_____ IDENTIFIED GENDER:_____
SEXUAL ORIENTATION: _____
ADDRESS: _____
PHONE NUMBER(S):_____

Parent/Legal Guarding Information

NAME OF PARENT/GUARDIAN:_____
RELATIONSHIP:_____ PREFERRED LANGUAGE(S): _____
PHONE NUMBER(S):_____

Reason for Referral

PLEASE BE SPECIFIC:
_____
_____
_____

Completed By

STAFF NAME:_____ PHONE NUMBER:_____
AGENCY NAME:_____ DATE SUBMITTED:_____

***Please submit to designated CAPPS Provider and/or CAPPS Practice Lead.**