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
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.