



ARLINGTON COUNTY, VIRGINIA  
OFFICE OF THE PURCHASING AGENT  
2100 CLARENDON BOULEVARD, SUITE 500  
ARLINGTON, VA 22201

AGREEMENT NO. 23-JDRC-EP-456  
AMENDMENT NUMBER 1

This **Amendment Number 1** is made on the date of execution by the County and amends **Agreement Number 23-JDRC-EP-456** ("Main Agreement") dated December 12, 2022 between **The Center for Clinical and Forensic Services, Inc.** ("Contractor") and the County Board of Arlington County, Virginia ("County").

The County and the Contractor agree to amend the Main Agreement as follows:

1. **PURSUANT TO PARAGRAPH 4. CONTRACT TERM, THIS AGREEMENT IS HEREBY RENEWED FROM NOVEMBER 29, 2023 TO NOVEMBER 28, 2024.**
2. **REMOVE PARAGRAPH 20. COVID-19 VACCINATION POLICY FOR CONTRACTORS.**
3. **REPLACE EXHIBIT A: SCOPE OF WORK AND CONTRACT PRICING WITH THE REVISED EXHIBIT A: SCOPE OF WORK AND CONTRACT PRICING ATTACHED**

All other terms and conditions of the Main Agreement remain in effect.

WITNESS THESE SIGNATURES:

THE COUNTY BOARD OF ARLINGTON  
COUNTY, VIRGINIA

DocuSigned by:  
 SIGNATURE: Antonino Mautino  
 PRINT: Antonino Mautino  
 TITLE: BUYER  
 DATE: 10/23/2023

THE CENTER FOR CLINICAL AND FORENSIC  
SERVICES, INC.

DocuSigned by:  
 SIGNATURE: Kathy Nowers  
 PRINT: Kathy Nowers  
 TITLE: Director of operations  
 DATE: 10/22/2023



**THE CENTER FOR CLINICAL  
AND FORENSIC SERVICES, INC.**

10505 Judicial Drive, Suite 100  
Fairfax, Virginia 22030  
703-278-0457 • Fax 703-385-1053

**Psychosexual Assessments, Evaluations  
and Treatment Services Contracting for  
Arlington Juvenile and Domestic Relations District Court**

**Service Rates Effective: November 29, 2023 to November 28, 2024**

**Scope of Work:**

CCFS will provide Assessments/Evaluations and Treatment Services to clients identified by the Arlington Juvenile and Domestic Relations District Court. CCFS clinicians have expertise in sexual offending, sexual trauma/victimization, general trauma, violence, and reentry after incarceration. Our primary treatment philosophy is cognitive behavioral in orientation, but we pull from a variety of other approaches including attachment, family systems, multi-systemic, and good lives model for intervention strategies that fit the needs of the client/family. In addition, our clinicians utilize a trauma informed approach in all applicable cases.

**Provider Services and Rates:**

**Psychosexual Risk Assessment** – A comprehensive evaluation of individuals who have sexual behavior problems or committed sexual offenses. Consists of clinical interviews, record reviews, collateral contacts, use of risk assessment tools and psychological testing (if recommended). \$1,200.00 Onsite  
\$1,500.00 Offsite

**Specialized Group Therapy** – CCFS provides a number of specialized programs related to sexual abuse and violence and this service represents the group therapy component of those programs. Examples of specialized groups include sexual offender groups, young children with sexual behavior problems groups, survivors' groups (sexual victimization), parent psychoeducational groups (SAFE), groups involving teens being sexually exploited, and general violence recidivism. \$115.00  
Adult - 90 min.  
\$95.00  
Juvenile – 75 min.

**Specialized Individual Therapy** – Psychotherapy for adolescents or adults struggling with issues related to sexual offending, sexual victimization/exploitation, sexual boundaries, sexual maladjustment, or violence/aggression. Play therapy for children who display problems related to sexual victimization, sexual exposure, trauma, or sexual reactivity. \$130.00 Hour

**Specialized Family Therapy** – Psychotherapy for families who have been impacted by sexual abuse or violence. This service can be utilized in conjunction with other services for one of our specialized programs or alone. This service may also be used for family reunification or to assist with a juvenile's transition back to the community. \$130.00 Hour

**Contacts for Referrals:**

To make a referral for an adult, please contact:

Celena Gates Bryant, Psy.D., LCP, CSOTP, Clinical Director  
703-278-0457, ext. 1014  
[celenagates@ccfsinc.net](mailto:celenagates@ccfsinc.net)

To make a referral for a child or adolescent, please contact:

Ms. Shannon Morris, LPC, CSOTP, Director of Child and Adolescent Services  
703-278-0457 Ext. 1016  
[shannonmorris@ccfsinc.net](mailto:shannonmorris@ccfsinc.net)

**Referral Process:**

Complete the attached Referral Form and send to Dr. Bryant for adult referrals or Ms. Morris for juvenile referrals.

THE CENTER FOR CLINICAL AND FORENSIC SERVICES, INC  
10505 JUDICIAL DRIVE, SUITE 100  
FAIRFAX, VIRGINIA 22030  
PHONE: 703-278-0457  
FAX: 703-385-1053

## Referral Form

This form is used for making a referral for an evaluation. Once a written report is completed, it will be forwarded to you.

Date: \_\_\_\_\_

### Referral Information:

Person making referral: \_\_\_\_\_

Name of agency/organization: \_\_\_\_\_

Phone number(s) of person making referral: \_\_\_\_\_

Who do you want us to contact to set up the appointments?

Contact name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Did you have the client sign a release of information?    Yes            No

Who receives a copy of report (include name and address, fax number, or email):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Billing Information:

What is the source of funding for this service? \_\_\_\_\_

Please attach a purchase order or provide the following information:

Name of person authorizing funding: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Client Information:**

Name of referral/client: \_\_\_\_\_

Date of birth/age: \_\_\_\_\_

Sex:            Male            Female

Reason for referral (Please provide a narrative description of any length and/or attach documents that describe the referral issue):

Where is client residing now and what is his/her discharge date, if applicable?

\_\_\_\_\_

If the client is in residential placement, what is discharge plan (include who would live in the home if known)? \_\_\_\_\_

\_\_\_\_\_

Is the client receiving mental health services of any type currently? If so, what are they? \_\_\_\_\_

\_\_\_\_\_

Does the client have a history of substance abuse problems?      Yes      No

Does the client have a history of sexual abuse?      Yes      No

Please attach any pertinent records/information you have regarding the case or the client (school records/psychologicals, police reports, etc.)

Please provide a list of all of the problematic sexual behaviors observed or noted:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any special requests or concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_