NO LIMITS RESIDENTIAL CARE LLC

"WE DON'T TEACH LIMITS HERE — WE TEACH POTENTIAL."

FORM 7 — FAMILY THERAPY PARTICIPATION AGREEMENT

Client Name: _____
Date of Birth: _____
Record Number: _____

SECTION 2 — PURPOSE OF THIS AGREEMENT
Family engagement is essential to treatment success. The purpose of this agreement is to outline expectations for parent/guardian participation in monthly Child & Family Team (CFT) meetings and in family therapy when clinically appropriate. Consistent involvement supports permanency planning, reunification, and treatment outcomes.

SECTION 3 — REQUIRED FAMILY INVOLVEMENT
A. Child & Family Team (CFT) Meetings:
Parents/Guardians agree to participate in:
• **Monthly Child & Family Team (CFT) meetings**
• Additional CFTs as needed for crisis, safety, placement updates, or treatment changes
CFT participation is mandatory and required by NC DHHS, DSS, and the MCO.

B. Family Therapy When Appropriate:
• Family therapy will be recommended only when clinically appropriate
• Frequency is based on clinical recommendation, not a fixed minimum
• Sessions may be weekly, biweekly, monthly, or as indicated by the treatment team

SECTION 4 — SCHEDULING & ATTENDANCE EXPECTATIONS
Parents/guardians agree to respond to communication, attend all scheduled sessions, reschedule as needed, and participate actively and respectfully.

SECTION 5 — MULTI-FAMILY GROUPS (Optional but Encouraged)
Parents/guardians are encouraged to participate in multi-family groups focusing on communication, boundaries, parenting strategies, and trauma understanding.

SECTION 6 — IMPACT OF NONPARTICIPATION
Failure to participate in required CFTs or recommended family therapy may delay treatment progress, impact reunification timelines, and require notification to DSS, the MCO, or the Court.

SECTION 7 — COMMUNICATION STANDARDS
Parents/guardians agree to maintain updated contact information, respond promptly to communication, and collaborate respectfully with staff.

SECTION 8 — CONFIDENTIALITY & CONDUCT
All sessions follow HIPAA and NC DHHS confidentiality guidelines. Unsafe or hostile behavior may require rescheduling or intervention.

SECTION 9 — SIGNATURES
Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

Therapist/Clinical Staff Signature: _____ **Date:** _____

Facility Witness Signature: _____ **Date:** _____