

We Provide:

- The opportunity for consistent improvement in self esteem and behavior...
- A safe and supportive environment for children to learn how to properly handle failure and success....
- Structured activity setting where behavioral and social problems can be observed and resolved...
- Individual, group, and family therapy as well as specialized therapeutic services...
- Monthly parent group meetings to provide information on child's progress, discussion of relevant issues, and support.



Summer Schedule

After School Program

Monday - Thursday
3:30p.m. - 5:30p.m.

Summer Program

June - August, 2007
Monday - Thursday
8:30a.m. - 4:00p.m.

DaySpring Services of Arkansas
5537 Bleaux Ave Springdale AR 72762
(479) - 872-5580 | Fax: (479) - 872-5581

www.dayspringbhs.com



After School & Summer Program

Vision...

"To Give Our Communities a Choice and Our Consumers a Voice."



We Serve:

School age children and adolescents in need of mental health services. These students will be assessed to determine the need for a structured therapeutic setting to address the mental, emotional, or behavioral problems interfering with daily functioning. The goal is to help students learn the adaptive skills that will allow them to return to less restrictive social and educational settings.

In this structured environment, participants are given the opportunity to recognize their strengths and weaknesses, develop appropriate social and work habits, practice useful study skills, address their interpersonal relationship problems, and cope with their mental or emotional issues.

The DaySpring multidisciplinary team develops an individualized treatment plan based on the comprehensive assessment and the psychiatric evaluation. Close collaboration as a treatment team, establishing clear goals and expectations, and communicating them effectively provides supportive therapeutic services to students.

Ongoing case management by the clinical staff assures that needs and day-to-day issues are identified, assessed, and addressed.

Eligibility:

- **Grades 1st through 12th**
- **Sufficient intellectual function to benefit from program**
- **Signed consent from parent or guardian allowing participation**
- **Willingness of family to participate in therapy when needed.**
- **Child must not be actively suicidal or homicidal**
- **Meeting Screening requirements for medical appropriateness**

COMMON CHALLENGES OF STUDENTS ATTENDING THIS PROGRAM ARE:

- **School avoidance, school phobia, or social anxiety**
- **Anxiety disorders**
- **Major depression**
- **Post traumatic stress disorder**
- **Oppositional defiant disorder**
- **Conduct disorder**
- **Disruptive school behavior**
- **Attention deficit disorder**
- **Bipolar disorder**

Program Referral Form

Student Information

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____

Male Female Race: _____

DOB: ____ / ____ / ____

SSN: ____ / ____ / ____

Name of School: _____

Current or most recent grade completed: _____

Presenting Challenges of Student:

Parent/Guardian Information

Name: _____

Address: _____

City: _____ Zip: _____

Contact Phone #: _____

Relationship to Student: _____

Referral Source Information

Person making referral: _____

Agency making referral: _____

Address: _____

City: _____ Zip: _____

Contact Phone #: _____