

**Care Services**

| **Care Services** | Needed | Explain the need |
| --- | --- | --- |
| Peer Support (PTSD or Mental Health support) | Please select |  |
| Transportation | Please Select |  |
| Medication Management | Please Select |  |
| Light cleaning | Please Select |  |
| Companion (i.e. board games) | Please Select |  |
| Meal Preparation | Please Select |  |
| Grocery shopping | Please Select |  |
| Personal services (i.e. set up an online service) | Please Select |  |
| Memory Care | Please Select |  |
| 24- hour Care | Please Select |  |
| Community Support (i.e. socialization Gym activities) | Please Select |  |