

Safety Profile for People Who use Augmentative and Alternative Communication
Augmentative Communication Community Partnerships-Canada

Safety concerns at HOME (Where you live most of the time)

Do you know what to do in the following situations?	I know what to do	I would like to learn more	Explain / Comment
1. Keeping your personal items safe from being stolen (e.g, money, clothing, electronics, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Keeping your personal information private (e.g., bank accounts, computer use, medical information, your private business, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Someone borrows money and doesn't pay you back (or borrows something and doesn't return it)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Your attendant hasn't shown up (e.g., contacting someone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. The fire alarm is activated? (e.g., trusting that the staff knows what to do)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>6. Answering the door (e.g., knowing who is at the door, giving permission to enter, locking and opening your door, etc.)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>7. Someone threatens you?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>8. Someone physically hurts you?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>9. Someone is controlling you (e.g., not allowing you to make your own decisions, pressuring you to do things you don't want to do, etc.)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>10. Someone forces you to do sexual things against your will?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>11. Someone punishes you (e.g., puts on your brakes, withholds food, takes away your communication display and/or VOCA, etc.)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>12. Someone who provides services does not know how to handle you (e.g., lift, feed, dress, etc.) and you are afraid for your safety?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>13. You are not satisfied with the safety practices of people who work with you (e.g., their personal hygiene, knowledge of safety procedures, etc.)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>14. Someone makes you feel afraid or uneasy?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>15. Other: Please specify.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No	