



## Nebraska Self Employment Services

### Self Employment Assessment and Referral

Client Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, and Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 County: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Business Type: \_\_\_\_\_  
 Counselor: \_\_\_\_\_ Office City: \_\_\_\_\_  
 Case #: \_\_\_\_\_ Counselor Phone: \_\_\_\_\_

*Once this form is complete and submitted to The Abilities Fund, an application (Informed Choices) will be sent directly to the client either by Email or U.S. Mail. Select how you want the Informed Choices application delivered to the client:*

**Select Informed Choices Delivery Method**

Electronic via Email Link

**Date Form Completed:** \_\_\_\_\_

Hardcopy via Traditional US Mail

*Please save this completed "Self Employment Assessment and Referral" form and fax to Christine Hess at 402-296-0265 or mail to: The Abilities Fund, P.O. Box 394, Plattsmouth, NE 68048*

Please add comments/notes to clarify the applicant's current level of functioning related to self employment

	Yes	No	Unknown	Comments/Notes
1. Is the applicant's health condition stable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the applicant have health care coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the applicant ever unable to work because of his/her health condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the applicant need lengthy or frequent breaks during the work day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the applicant had a hospital stay in the past year because of his/her disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is it likely that the applicant will have a hospital stay in the next year because of his/her disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does the applicant's disability affect his/her memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- |                                                                                                                                                    |                          |                          |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 8. Does the applicant's disability affect his/her ability to concentrate or stay focused?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the applicant's disability affect his/her ability to communicate with other people?                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does the applicant's disability affect his/her mobility?                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is it likely that the applicant's health condition will worsen over time?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does the applicant currently use any assistive devices or technologies?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is it likely that the applicant will require additional assistive devices or technologies to operate his/her business? If so, please describe. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does the applicant require any accommodations? If so, please describe.                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Based upon this assessment, is the applicant a good candidate for business ownership?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Does the client currently receive Social Security benefits?                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does the client currently receive Veterans benefits?                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*Please use the space below to provide additional information and direction regarding this client's interest in self-employment.*

**Additional Information**