

SCAF ADOPT-A-WARRIOR INITIATIVE DONOR REGISTRATION FORM

Thank you for your interest in deciding to adopt-a-warrior (beneficiary). By filling this form, you are accepting to take up some responsibility for the healthcare or welfare of a person living with sickle cell disorder.

If your application is approved, you will be matched with a suitable warrior and given an Adoption certificate.

START HERE

1. Provide the following information about yourself

Family Name:	First Name:	Middle Name:
Sex	(F)	(M)
Identification:	Identity Number:	Occupation:
Date of Birth:	Place of Birth:	
Home Address:		
Email address:		
Contact Number:		
Details of Next of Kin: Name/Relationship/Contact Details		

2. Financial Implications of Adoption

Beneficiaries approved by SCAF for this initiative are classed as indigent and thus require assistance in the following areas in order to live healthy and contribute effectively to the society.

Please note: Where donations are in surplus for your adopted beneficiary, it may be transferred to another. Tick to Opt in [] Tick to Opt out []

If you tick to opt out, your funds would be returned to you

Please tick your favorable adoption plan (One option from stage 1 to 5).

Stages	Financial Implications (Costs are calculated in Naira)	Tick to indicate preferred option	Comment
Stage 1: Provision of drugs	Monthly cost: N2,000 Yearly Cost: N24,000		
Stage 2: Provision of drugs Payment of routine medical bills Provision of school fees	Cost for medical bills and drugs. Monthly: N 5,000 Yearly: N 60,000 School fees: Fixed rate N25,000 Total Monthly package: N30,000 Total Yearly Package: N85,000		
Stage 3: Payment of surgical bills or upkeep for	Estimated fixed cost is dependent on the surgical process or upkeep needed:		

beneficiaries in care home	N2,000,000 – N5,000,000		
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2a. Optional Adoption Plans

Stages	Financial Implications	Tick to indicate Preferred Option	Comment
Stage 4: Payment of school fees	Fixed rate of N25,000		
Stage 5: Payment of Emergency medical bills	Monthly cost: N10,000		
	Yearly Cost: 120,000		

3. Preferred Age of Beneficiary:

Please note that as regards the first two age brackets, you may have to interact with the parents of the beneficiaries as firsthand contact.

Major needs: *D-Drugs, MB- Medical bills, EMB- Emergency Medical bills, SB- Surgical bills

Age of Beneficiary (Major needs)	Tick as Preferred
0 – 12 (D, MB)	
13 – 18 (D, MB, EMB)	
19 – 25 (D, MB, EMB, SB) <i>(These are beneficiaries who due to repeated ill health have at some point had to withdraw from education or re- sit classes)</i>	
26 and Above (D, MB, EMB, SB) <i>(These are beneficiaries who due to repeated ill health have at some point had to withdraw from education or re- sit classes)</i>	

4. Linkage with beneficiary

Please tick the desired contact level you would want to have with your beneficiary.

Linkage Options	Tick as Preferred
Direct Involvement (Contacting the beneficiary directly for updates as to finance, health etc.) <i>Please note that this comes with emotional implications– a member of SCAF would contact you to discuss this.</i>	
Distanced Involvement (SCAF will contact you with beneficiary update)	
Both	

5. Donations

Donations may be made monthly, quarterly, bi-annually or yearly. It should be made directly to SCAF. Please tick your preferred donation options.

Donations	Tick as Preferred
Monthly	
Bi-annually	

Payments are to be made directly to SCAF in line with the attached agreement

Account Details:

Sickle Cell Aid Foundation

Zenith Bank Sort Code: 057080358

Account Number: 1012488295

Signature of Applicant _____

Date of Application _____

Please Note:

- Where there has been delayed payment on three consecutive payment due dates, SCAF reserves the right to withdraw your adoption rights.
- All information regarding the welfare of the beneficiary is to be kept confidential except required by law to disclose.

Disclaimer: Please note that this does not include taking up parental responsibilities.

For SCAF's Use Only

Decision on Adoption Application (F) _____ (U) _____

Name of Beneficiary Assigned _____

Contact info: _____

Signature of Adoption officer _____

Date _____