# THE ELIZABETH FOUNDATION SS

**SICKLE CELL AWARENESS & SUPPORT INITIATIVE**

**Non-Profit Organisation** | **CAC/NGO Reg No:** 8391820
**Address:** Elizabeth Foundation SS Clinic Hub, Oluyole, Ibadan, Oyo State
**WhatsApp:** +234 812 902 1662 | **Email:** elizabethfoundationss21@gmail.com

## WELFARE & BENEFICIARY ASSISTANCE APPLICATION FORM

**(Oyo State [Ibadan] and Lagos State Operations)**

**Application Date:** ..... **App Reference No:** .....

## SECTION A: APPLICANT / PARENT / GUARDIAN INFORMATION

**Full Name:** .....

**Date of Birth (DOB):** ..... **Sex:** ☐ Male ☐ Female

**Residential Address:** .....

**City:** ..... **State:** ☐ Oyo (Ibadan) ☐ Lagos State

**Telephone:** ..... **WhatsApp No:** .....

**Email Address:** .....

**Preferred Contact:** ☐ Phone Call ☐ WhatsApp ☐ Email ☐ SMS

**Next of Kin Name:** ..... **Relationship:** .....

**Next of Kin Tel:** .....

## SECTION B: SECTOR ASSISTANCE REQUESTED

☐ Children with Sickle Cell (SS) Support
☐ Elderly Care Monthly Allowance
☐ Youth Empowerment Support
☐ Widow Support Program
☐ Single Parent Relief Assistance
☐ Food Bank & Emergency Relief

## SECTION C: APPLICANT / DEPENDENT MEDICAL DETAILS

**Genotype:** ☐ SS ☐ AS ☐ AA ☐ Other **Blood Group:** ☐ A ☐ B ☐ AB ☐ O (☐ + / ☐ - )

**Registered Hospital:** ..... **Hospital Location:** .....

**Current Medications:** .....

**Family Health Notes:** .....

## SECTION D: CHILD SCHOOL FEES ASSISTANCE (AGES 2–16 YEARS)

**Mandatory Payment Policy:** All approved school fees allowances are paid **DIRECTLY into the child's school bank account** only. Capped strictly at **one (1) child per family**.

**Child's Full Name:** .....

**Child's DOB:** ..... **Child Genotype:** ☐ SS ☐ AS ☐ Other

**Child Medications:** .....

**Name of School:** .....

**School Address:** .....

**Principal / Head:** ..... **School Phone:** .....

**Class / Grade:** ..... **Termly Fees Amount:** .....

**School Bank Name:** ..... **School Account No:** .....

**School Account Title:** .....

## SECTION E: ELDERLY CLIENT MONTHLY ALLOWANCE & BANK DETAILS

**Elderly Support Notice:** Monthly allowances require mandatory background assessment before approval. Payments are disbursed to the verified personal bank account below.

**Account Holder Name:**

Account Number: .....

THE ELIZABETH FOUNDATION SS
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## SECTION F: TERMS, CONDITIONS & LEGAL DECLARATION

Under the Laws of the Federal Republic of Nigeria and NGO Statutory Guidelines:

1. **Direct School Disbursement:** School fee support is paid directly to verified school bank accounts. No direct cash transfers are made to parents for school fees.
2. **Assessment & Non-Guarantee:** Monthly allowances and grants are not guaranteed upon application and depend on evaluation results and funding availability.
3. **Integrity of Claims:** Any fraudulent bank details or false health declarations will trigger automatic disqualification and legal reporting.
4. **Data Security:** Confidentiality is preserved under the Nigeria Data Protection Act (NDPA).

## SECTION G: UNDERTAKING & SIGNATORIES

### 1. APPLICANT / PARENT

I confirm all details are accurate.

Signature & Date

### 2. GUARANTOR / RELATIVE

Name: .....

Signature & Date

### 3. NGO ASSESSMENT OFFICER

Status: [ ] Approved [ ] Deferred

Stamp & Authorized Sign

YOU MAKE THE DIFFERENCE

# THE ELIZABETH FOUNDATION SS

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# OFFICIAL MEMBERSHIP REGISTRATION FORM

**(Oyo State [Ibadan] and Lagos State Operations)**

**Registration Date:** ..... **Member ID No:** .....

## SECTION 1: MEMBER PERSONAL PROFILE

**Full Name:** .....

**Date of Birth (DOB):** ..... **Sex:** ☐ Male ☐ Female

**Residential Address:** .....

**City:** ..... **State:** ☐ Oyo (Ibadan) ☐ Lagos State

**Telephone:** ..... **WhatsApp No:** .....

**Email Address:** .....

**Preferred Contact:** ☐ Phone Call ☐ WhatsApp ☐ Email ☐ SMS

**Next of Kin Name:** ..... **Relationship:** .....

**Next of Kin Tel:** .....

## SECTION 2: MEMBERSHIP CATEGORY & SECTOR INTEREST

☐ Sickle Cell (SS) Advocate / Patient
☐ Senior Citizen / Elderly Care Member
☐ Youth Empowerment Participant
☐ Widow Support Community
☐ Single Parent Household
☐ Food Bank Welfare Volunteer/Beneficiary

## SECTION 3: HEALTH & MEDICAL BACKGROUND

**Genotype:** ☐ SS ☐ AS ☐ AA ☐ Other **Blood Group:** ☐ A ☐ B ☐ AB ☐ O (☐ + / ☐ - )

**Registered Hospital:** ..... **Hospital Location:** .....

**Current Medications:** .....

**Family Medical Notes:** .....

## SECTION 4: CONSTITUTIONAL RULES & TERMS OF MEMBERSHIP

By registering as a member of The Elizabeth Foundation SS under Nigerian NGO regulations:

1. **Non-Transferable Membership:** Membership status is personal and subject to compliance with the foundation's rules and ethical guidelines.
2. **Verification & Transparency:** Members must provide truthful records and consent to verification of medical or personal data in accordance with the Nigeria Data Protection Act (NDPA).
3. **Welfare Grants Notice:** General membership does not guarantee immediate financial or material disbursement. Separate beneficiary application assessments apply.

## SECTION 5: UNDERTAKING & SIGNATURES

### 1. MEMBER SIGNATURE

I confirm all details are correct.

Signature & Date

### 2. GUARANTOR / NEXT OF KIN

Name: .....

Signature & Date

### 3. NGO OFFICIAL SIGN

Staff Name: .....

Authorized Stamp & Date

YOU MAKE THE DIFFERENCE