Sharing Hearts Fund for Pediatric Wellness
Application for Funding

Liberty HealthShare®

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The Sharing Hearts Fund provides financial support for families in need related to pediatric wellness.

Helping with physical exams, dental exams and cleaning, vision exams and eyeglasses, and hearing tests.

Families seeking funding will go through an application process during which they will identify their desired procedure and demonstrate their financial need.

The paper application is on the front and back of this sheet, or you can apply online at **www.libertyhealthshare.org/sharing-hearts**. Applications open **September 1, 2025.** All applications received by **5pm on September 30, 2025** will be considered for funding in this cycle of grant awarding.

Please mail this filled-out application to:

ATTN: Sharing Hearts Fund
Liberty HealthShare
4455 Hills & Dales Rd NW
Canton, OH 44708

To learn more, contact us at sharinghearts@libertyhealthshare.org or 330-942-0268.

The Sharing Hearts Fund for Pediatric Wellness is a charitable extension of Liberty HealthShare. All dollars to be awarded are generated through donations and grants, separate and distinct from the normal operations of the Liberty HealthShare healthcare sharing ministry.

Applicant Information

All questions are required.

Full Name:	Phone Number:
Address:	Email Address:

Child Requiring Services

Full Name:	
Date of Birth: _____ / _____ / _____	Gender: ○ Male ○ Female

Screening Information

Do you have health care coverage?	○ Yes ○ No
Have you applied for Medicaid?	○ Yes ○ No
Do you currently receive state public assistance (e.g., Food Stamps, basic welfare support)?	○ Yes ○ No

Statement of Need

Briefly explain why the financial support of the Sharing Hearts Fund is necessary to make the medical service you are seeking for your child possible.

Medical Information*

*Please call and confirm this information with your provider prior to submitting your application. When you call, inform them you will be a self-pay patient and they will not have to negotiate with insurance on your behalf.
***Please Note: Don't let uncertainty around a provider keep you from applying. We can connect you with providers.** Families having difficulty identifying a provider should contact Diana Willey, Sharing Hearts Fund Coordinator at **sharinghearts@libertyhealthshare.org** or **330-942-0268**.

Requested Medical Procedure or Service (dental cleaning, vision exam, physical exam, etc):	Estimated Cost: $
Healthcare Provider Name:	Provider Phone Number:
Provider Address:	

Household Income Information

Total Gross Monthly Income: $_____

Have you considered any other forms of financial support for this medical need? If so, what form of financial support?

If so, what was the outcome of seeking a different form of financial support?

Acknowledgment & Authorization

I understand that the **Sharing Hearts Fund** may verify the information provided to determine eligibility for financial assistance.

I affirm that the above information is true and correct to the best of my knowledge. I acknowledge that if any financial information provided is found to be false, financial assistance may be denied. I also understand that an authorized **Sharing Hearts Fund** representative may contact me for additional information.

Applicant Signature: _____ Date: ____ /____ /____