



## Cost of Living Stipend for Economically Disadvantaged Residents

### *Registration Form*

If you are eligible for the stipend, *please complete this form and return it via email with a copy of your notification of approval for the AAMC's Fee Assistance Program (FAP) to: [Benefits@challiance.org](mailto:Benefits@challiance.org)*

(Note: If you cannot find the email from AAMC confirming your approval for the FAP program, you can obtain verification by contacting [FAP@AAMC.org](mailto:FAP@AAMC.org). Please request they cc: [Benefits@challiance.org](mailto:Benefits@challiance.org) when providing you with the verification.)

Name: \_\_\_\_\_

Residency Program: \_\_\_\_\_

Phone: \_\_\_\_\_ (cell phone # preferred)

Address where stipend check should be sent (in June/July):

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#### Attestation:

I affirm that I continue to experience challenging financial circumstances.

I understand that this stipend is taxable income.

I understand that this stipend is being paid in connection with my expected participation in a residency training program at Cambridge Health Alliance, commencing in June or July, 2025. I understand and agree that I am required to re-pay the stipend to Cambridge Health Alliance, in full and on a timely basis, if for any reason I do not attend the training program as planned.

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Full Name

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Date

Note: Your appointment at CHA will need to be finalized prior to payment of the \$10K cost-of-living stipend for 2025-26. Please ensure that you respond promptly to correspondence related to the hiring and credentialing processes.