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

*(*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. *Please request they cc 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):_____
_____

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, 2024. I understand and agree that I am required to re-pay the stipend Cambridge Health Alliance, in full and on a timely basis, if for any reason I do not attend the training program as planned.

_____ _____
Full Name Date

Note: Your appointment at CHA will need to be finalized prior to payment of the $10K cost-of-living stipend for 2024-25. Please ensure that you respond promptly to correspondence related to the hiring and credentialing processes.