



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, 2026. 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.

Full Name

Date

Note: Your appointment at CHA will need to be finalized prior to payment of the \$10K cost-of-living stipend for 2026-27. Please ensure that you respond promptly to correspondence related to the hiring and credentialing processes.