FORM MD-06
SOCIOECONOMIC DRIVER REPORT

Medical Aid in Dying — Non-Terminal Provision

PROTECTED B

Statutory Authority: Act § 6 (Mandatory Reporting)

INSTRUCTIONS: This form must be completed for all MAiD provisions where the applicant is not terminally ill (Track 2). It must be transmitted to the Ministry within 30 days of provision. Failure to report is a violation of the Act.

SECTION A: CASE IDENTIFICATION

APPLICANT FILE ID	DATE OF PROVISION (YYYY-MM-DD)	PROVINCE / TERRITORY

SECTION B: CLINICAL ELIGIBILITY BASIS

☐ Applicant demonstrated decisional capacity pursuant to § 2 of the Act.

☐ Assessment period of 90 days was completed or waived via exception.

PRIMARY DIAGNOSIS (ICD-11 CODE PREFERRED): _____

SECTION C: SOCIOECONOMIC DRIVERS (MANDATORY)

Identify any factor cited by the applicant as a primary or contributing reason for the request.

1. HOUSING STATUS (Check all that apply)

☐ Applicant had stable, adequate housing.

☐ Applicant was unhoused or in emergency shelter.

☐ Applicant resided in housing they deemed inadequate for their disability needs.

☐ Applicant was under eviction notice or imminent risk of homelessness.

2. INCOME AND FINANCIAL SECURITY

☐ Applicant reported sufficient income to meet basic needs.

☐ Applicant reported insufficient income for basic needs (food, shelter, medication).

☐ Applicant cited disability support payments (e.g., ODSP, AISH) as insufficient.

3. CARE AND SUPPORT AVAILABILITY

☐ Applicant had access to required care/support services.

☐ Applicant required services that were UNAVAILABLE in their jurisdiction.

☐ Applicant required services that were WAITLISTED beyond a clinically acceptable time-frame.

☐ Applicant cited social isolation or lack of community connection as a driver.

SECTION D: ALTERNATIVES PRESENTED & OUTCOME

For every driver identified in Section C, indicate the outcome of resource presentation.

RESOURCE CATEGORY	OFFERED & DECLINED	ACCEPTED BUT FAILED	NOT AVAIL
Housing Assistance	☐	☐	☐
Income Supplement / Disability Aid	☐	☐	☐
Home Care / Personal Support	☐	☐	☐
Palliative / Pain Management	☐	☐	☐
Psychiatric / Mental Health Care	☐	☐	☐

SECTION E: ATTESTATION — PROVIDER, APPLICANT, AND WITNESS

Provider Attestation: I certify that I have presented all available alternatives to the applicant. Where "Not Available" is selected above, I certify that no such resource exists or is accessible to the applicant in this jurisdiction within a clinically relevant timeframe.

SIGNATURE OF PROVIDER_____ DATE SIGNED_____

Applicant Countersignature: I confirm that the information recorded in Sections C and D accurately reflects the reasons for my request and the outcome of alternatives presented to me.

SIGNATURE OF APPLICANT_____ DATE SIGNED_____

Independent Witness: I was present during the alternatives presentation recorded in Section D and attest that it was conducted as described above.

SIGNATURE OF WITNESS_____ DATE SIGNED_____
PRINTED NAME OF WITNESS_____ WITNESS ROLE / RELATIONSHIP_____

DISTRIBUTION: Original: Ministry of Health (MAiD Secretariat). Copy 1: Ministry of Social Services. Copy 2: Regional Coroner.