Becoming eligible for medical aid in dying requires patients meet several criteria:
Patients must voluntarily and independently request an evaluation from two participating providers. These providers must confirm that you are an adult resident of a state where medical aid in dying is legal, have a prognosis of six months or less, possess the mental capacity to make your own medical decisions, and are physically able to self-administer the prescribed medication. Suffering or having a specific plan is not required, and you are never obligated to take the medication once prescribed.

Verifying eligibility may take considerably longer than the mandated waiting period. If you think you may want this option at some point in your dying process, starting the process early can prevent unnecessary stress or urgency. Being deemed eligible does not require you to take the medications to die; it simply provides you with the option to do so.

We strongly recommend that you consider (and carefully choose!) hospice care:
Hospice services provide expert symptom management and compassionate support for loved ones, regardless of how your end-of-life journey unfolds. Hospice care—fully covered by Medicare and most insurance plans—ensures that you and your family receive attentive, comprehensive care through the final phase of life, no matter how you die.

Before choosing a hospice, ask about what aid-in-dying services they provide. Many hospices say they "support" patients considering medical aid in dying, but what that means in practice can vary considerably. Ask specific questions about their aid-in-dying policies and clinical roles:
- Can their hospice providers serve as the attending or prescribing clinician?
- Are staff trained and supported to provide clinical monitoring and coordination with prescribers?
- Are nurses allowed to prepare the medications and remain present at the bedside during the crucial last moments?
- Do they support alternate (non-oral) medication routes if those become needed?
- If the hospice refers patients to outside providers, what costs might be involved?

Remember that being eligible for hospice does not automatically mean you qualify for medical aid in dying. If you are not yet eligible, ask your provider to help identify when a reassessment might be appropriate.

Steps to becoming eligible:
To start the medical aid-in-dying process, a patient must make a direct request to a participating clinician who agrees to act as the attending provider. The attending provider documents the request, evaluates the patient's legal eligibility (prognosis, capacity, etc.), and counsels the patient about all their end-of-life care options.

Then, a separate consulting or confirming clinician must independently review the patient's records and verify eligibility. If there are questions about decision-making capacity, an additional assessment by a mental health professional may be required. In certain states, patients must also complete a written request that two individuals witness. Individuals requiring translation assistance must complete an additional language attestation form.

Once all legal and clinical requirements are met and the waiting period has elapsed, the attending provider may accept the second verbal request, complete final counseling, and issue the aid-in-dying prescription. The medication can be safely held at the pharmacy until the patient chooses to fill it, and delivery is usually prompt. No costs are incurred until the medication is dispensed.

Finding physicians, comparing fees and coverage, and understanding what bedside care is (and isn't) provided:

Aid-in-dying care is generally provided by three main types of clinicians, each differing in insurance acceptance, service fees, bedside availability, and overall responsiveness. The medications themselves are typically paid out of pocket and cost between $600 and $800.

1. Large medical organizations, particularly those with palliative care programs, typically cover aid-in-dying services under insurance, though it may take some time to get an appointment. Some provide the care free of charge, if needed. These services are generally offered through office visits, and in some cases, via telehealth. Bedside support is typically not offered, though they may make referrals to hospices, doulas, or volunteers.

2. Hospices that allow their clinicians to directly serve as attending prescribers do not charge additional fees, as Medicare and federal regulations prohibit billing for these services. If a hospice does not permit its providers to participate, patients may transfer to one that does, though this can delay the process. While some hospices can admit patients quickly, their teams typically take time to understand the needs of each patient and family to ensure competent, individualized care.

3. Independent physicians often provide highly attentive bedside care, including faster response times, home visits, and the ability to manage non-oral medication routes. Most charge a flat fee, though many offer a sliding scale based on need, and a few can bill insurance.

No matter where you receive your aid-in-dying prescription, bedside support is still crucial for end-of-life care. Hospice care is covered by Medicare and most insurance plans at 100%. Some hospices train and support their staff to prepare aid-in-dying medications, provide full monitoring, manage non-oral routes, and provide crucial bedside care during ingestion, while others do not.

Patients who live in a facility, or require an alternative location

If you live in a residential facility, ask about its policies on medical aid in dying. Skilled nursing facilities are legally permitted to prohibit aid-in-dying within their buildings. Assisted living and similar settings must allow residents to make their own choices in their own apartments or rooms, though the facility may refuse to accept and manage the medications. Policies can vary significantly by facility type. If aid in dying cannot occur where you currently reside, consider alternative arrangements, such as spending the day at a friend's or family member's home. Short-term rentals or hotels may also be possible, but the hotelier or the property owner should be informed that the patient is seriously ill and likely to die on the premises.

Patients who live in a US state where aid-in-dying is not legal

It is crucial to know that you cannot stay in your state and receive aid-in-dying care from out-of-state doctors. Patients must be physically present in the aid-in-dying state to make requests, receive an aid-in-dying evaluation, and, if appropriate, receive the medications. As well, patients must be physically present in the aid-in-dying state if or when they take the medicines to die. Generally, you cannot legally transport aid-in-dying medications across state lines except for neighboring areas of Oregon or Vermont (see details below). Since most non-aid-in-dying states have legal prohibitions against medical aid in dying, they may consider it an illegal assisted suicide, and anyone who helps you could be prosecuted.

Important: If you decide to travel to another state and ultimately choose to proceed with the medications to die, we recommend arriving at least 3–7 days in advance. Your condition is very likely to deteriorate, meaning you may be more fragile and require more care. This allows time for thorough evaluation and preparation, minimizing risks of adverse outcomes while ensuring a peaceful experience for you and your loved ones.

Note: Residency in U.S. aid-in-dying laws is about legal ties to a state, not time lived there. There is no "you must live here X days" rule in any statute; what matters is whether a clinician can reasonably document that a patient is a resident. Most jurisdictions restrict eligibility to state residents but define it by evidence of residence rather than by duration of residence. Typical proofs include a state driver's license or ID, voter registration, lease or property ownership, state tax return, or recent utility/insurance documents with an in-state address. The attending clinician decides whether residency has been adequately demonstrated, using this documentation, patient history, and stated intent. These States include Washington, California, Colorado, Hawaii, Maine, New Jersey, New Mexico, the District of Columbia, Delaware, and Montana.

Oregon and Vermont have eliminated residency requirements from their aid-in-dying laws. Patients from other states may access MAID there if they meet all clinical criteria, complete required evaluations and requests in-state, and are physically present in the state for prescribing and ingestion.

We encourage careful consideration of the financial and emotional burdens of moving across state lines for aid-in-dying. While doctor consultations and hospice care may be covered by insurance, the costs of medication, travel, accommodations, and other expenses are most likely not covered. It is often very difficult for terminally ill patients, who may be quite sick, to be moved away from familiar surroundings and loved ones, and they may decline rapidly as a result. Please thoroughly explore your hopes and worries about your end-of-life, and consider other alternatives carefully.

For patients who are not yet terminal, but interested in making plans for their possible future

While it's always valuable for you and your doctors to discuss your thoughts, hopes, and concerns about the end of life, it may not be practical to make detailed plans for aid in dying at this time—especially if your physicians have indicated that you do not currently have a life-limiting illness or prognosis. Your plans and conversations will likely evolve as your health and care teams change. Your support for aid-in-dying is deeply appreciated. However, this may or may not become a personal option depending on your future medical circumstances. If managing symptoms becomes difficult, palliative care may help improve your quality of life. When you are closer to meeting the legal criteria for aid in dying, we strongly recommend exploring hospice care, as described above. The Academy can offer guidance and referrals when that time comes. In the meantime, please read our free patient guide.

~updated 1/2026