AGREEMENT TO SELL PROPERTY

MEDICAID NO.	MEDICAID CLAIMANT

This agreement is needed to determine if an individual can receive Medicaid on a conditional basis. If this agreement is made by or with respect to an individual filing for or receiving Medicaid benefits, no benefits can be paid under this program unless this form is properly completed and filed as required by existing regulations (20 CFR 416.1240). If this agreement is made by and with respect to an individual who is not filing for or receiving benefits but whose resources affect the eligibility of another individual for benefits, this agreement is required by regulations (20 CFR 416.1240, 416.1202, 416.1203). This form is maintained in the claimant case file to document the agreement. The Alabama Medicaid Agency will further explain these uses upon request.

DESCRIPTION OF PROPERTY (ADDRESS OR LOCATION)	NAMES OF OWNERS	NATURE AND PERCENTAGE OWNERSHIP OF EACH	ESTIMATED CURRENT MARKET VALUE	AMOUNT OWED ON RESOURCE IF ANY
1.				
2.				

CONDITIONS OF AGREEMENT: My resources exceed the amount which an eligible individual may have and still qualify for benefits under Medicaid. I hereby request that conditional eligibility be made to me until I can sell the above-described resources at their current market value. Once the Alabama Medicaid Agency notifies me that the agreement has been approved, I agree to take all necessary and proper steps to sell the above-described resources and to actively continue my efforts to do so until the resources are sold. I agree to sell the above-described resources for the best price I can get. I also agree to report to the Alabama Medicaid Agency at least every 90 days on the status of the attempts to sell the property and to notify the Alabama Medicaid Agency within 5 (five) working days after I complete the sale. I understand that periods in excess of 7 (seven) days during which no attempt is made to sell voids this exclusion. I also agree to, upon sale of the property, promptly reimburse the Alabama Medicaid Agency for expenditures by the Agency on my behalf during the period of time wherein property was for sale. I understand that the amount of reimbursement due the Alabama Medicaid Agency will not exceed the value of my interest in the property.

SIGNATURE	ADDRESS (Street and No.)	CITY/ STATE, ZIP	DATE
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1. File 2. Claimant 3. DO Control