



APPLICATION

**TEMPORARY MEDICAL HARDSHIP MANUFACTURED DWELLING
(Non-Resource Zone)**

File #

Fee: \$
(SEE CURRENT FEE SCHEDULE)

**ALL SECTIONS MUST BE COMPLETED. ATTACH ADDITIONAL SHEETS IF NECESSARY.
REVIEW WILL BEGIN ONLY WHEN THE APPLICATION IS DETERMINED TO BE COMPLETE**

I. Property Owner(s) Information

Name(s): _____ Phone #1: _____

Mailing Address: _____ Phone #2: _____

City: _____ State: _____ Zip: _____ Email: _____

II. Applicant Information

Name(s): _____ Phone #1: _____

Mailing Address: _____ Phone #2: _____

City: _____ State: _____ Zip: _____ Email: _____

Other individuals to be notified of this application: Name, Address, City & Zip, or Email

III. Property Information

Site Address: _____

Assessor's Map & Tax Lot Number: T _____ S, R _____ W, Section(s) _____, Tax Lot(s) _____

Acreage: _____ Zoning: _____ Fire District: _____

Water Supplied By: _____ Sewage Disposal Type: _____

Existing Structures: _____

Current use(s) of the property: _____

IV. Request Summary (Example: "Establish a medical hardship for the care of my mother")

V. Attached Documentation: With all land use applications, the "burden of proof" is on the applicant. It is important that you provide **ALL** the information listed on the following pages at the time you submit your application. The processing of your application does not begin until the application is determined to be complete.

Name of person(s) with medical condition: _____

Relationship to residents on property: _____

Name of person who will provide care: _____

Relationship to person with medical hardship: _____

Name of person who will occupy manufactured dwelling: _____

Attachments

Signed "Medical Need Statement" form (see page 3).

- Signed "Authorization to Use or Disclose Health Information" form (see page 4).
- A copy of deed covering the subject property, showing the current ownership of the land.
- A copy of any easements for or on the subject property.
- A scale drawing of the property boundaries. Include the locations of existing and proposed structures (house, garage, shop, barn, manufactured home, well, septic tank and drain field, driveway, setbacks, etc.). Label all tax lots.
- Is the only access or proposed access to the property via a road that crosses a railroad? _____ If yes, please draw the location on your map and explain here: _____

I understand that the following restrictions apply:

1. This permit must be renewed annually.
2. Tenancy of the manufactured dwelling shall be limited to the family member identified above.
3. This permit is valid only for the owner(s) of the property and does not transfer to a new owner.
4. The manufactured dwelling must be removed upon sale of the property or within three months of when the need for the manufactured dwelling no longer exists.
5. The manufactured dwelling shall be connected to the existing water supply and septic system, if authorized by the County Sanitarian.
6. Installation of a second septic system does not vest a right to a second permanent residence.
7. Additional permits are required to connect to the septic system or install a new system, to place the manufactured dwelling, and to make electrical and plumbing connections. If the manufactured dwelling is connected to the existing septic system, continued use must be authorized by the County Sanitarian every two years.
8. A covenant recognizing the aforementioned items will be required.
9. A covenant recognizing resource use on adjacent farm or forest land will be required, if applicable.

Note: *The temporary placement of a Medical Hardship Dwelling may require improvement of the driveway to the standards of the fire district. Applicants are encouraged to contact their fire district and the Community Development Department for more information.*

Assessed Property Value Notice

This action or any future related action(s), if approved, may result in a change to my property valuation, and therefore the tax amount I pay annually. I will contact the Assessor's Office at 541-766-6855 to discuss and understand potential property tax impacts.

I understand

I hereby certify that I am the legal owner or contract purchaser of the above noted property; that the information contained herein is true and accurate to the best of my knowledge; that the requested permit will

Medical Need Statement

Name of Patient: _____ (for two patients, photocopy this form)

To be completed by the attending physician:

Describe the daily health care needs of the patient listed above and the exact assistance he/she requires: _____

Based on my medical examination of my above-mentioned patient and my knowledge of his/her medical situation:

- I certify that the temporary residence is necessary to provide adequate and immediate health care for the family member who needs close attention and daily assistance.
- **I certify that this family member would otherwise be required to receive needed attention from a hospital or care facility.**

Attending Physician's Signature

Attending Physician's Printed Name

Date

Clinic/Facility Name

Phone Number

Note to the attending physician: If you have any questions, please contact the Benton County Community Development Department at (541) 766-6819.

