Benton County
COMMUNITY DEVELOPMENT DEPARTMENT

Community Development Departme
Office: (541) 766-6819
360 SW Avery Avenu
Corvallis, OR 9733
co.benton.or.us/cd

APPLICATION

TEMPORARY MEDICAL HARDSHIP MANUFACTURED DWELLING (Addition or Transfer)

Original Approval File #_____

Fee: $_____
(MINISTERIAL REVIEW FEE SEE 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)_____

IV. Request Summary (Example: Add Mr. Smith to the previously approved medical hardship dwelling)

_____

_____

V. Attached Documentation

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 previously approved medical hardship: _____

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: _____

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: _____

Attachments

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

☐ Signed "Authorization to Use or Disclose Health Information" form (**see page 4**).

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.*

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 not violate any deed restrictions attached to the property involved; and that I will acknowledge the above restrictions by signing a deed covenant for recording in the County Deed records.

_____ _____ _____ _____

Owner/Contract Purchaser Signature Date Owner/Contract Purchaser Signature Date

For Office Use Only: Application _____ Staff Received: _____ File Number: LU-_____

Submitted: Planner Assigned: _____ Date Application Deemed Complete: _____

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.

Authorization to Use or Disclose Health Information

Name of person requiring care: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make the disclosure: Benton County and its Community Development Department.
3. The type of information to be used or disclosed is as follows: All medical information submitted pursuant to this medical hardship dwelling application, including, but not limited to, medical chart information, communications to and from my physicians, diagnosis and medication reports and all other medical information submitted to substantiate the need for a medical hardship dwelling.
4. The information identified above may be used by or disclosed to the following individuals or organization(s): Benton County, a political subdivision of the State of Oregon, the Benton County Planning Commission, and any other persons entitled, under law, to receive information relating to this land use application.
5. This information for which I'm authorizing disclosure will be used for the following purpose: To comply with land use notification and public hearing requirements that all application materials be made available to the public upon request and/or pursuant to state and local laws and regulations.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Planning Official. I understand that written revocation will constitute a withdrawal of the application for a medical hardship dwelling. I further understand that the revocation will not apply to information that has already been released in response to this authorization.
7. This authorization will remain in effect for the duration of the retention period of the land use file under state archive laws.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified above is voluntary.

_____ _____

Signature of Applicant Date Signature of Person Requiring Care Date

If signed by a legal representative, printed name and relationship to applicant:

_____