Benton County
COMMUNITY DEVELOPMENT DEPARTMENT

Community Development Department
Office: (541) 766-6819
360 SW Avery Avenue
Corvallis, OR 97333
co.benton.or.us/cd

# CONDITIONAL USE PERMIT
(Temporary Medical Hardship in EFU and FC Zones)

**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 temporary medical hardship dwelling in existing shop building")

_____

**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.

**Conditional Use Criteria to Address:**

On a separate piece of paper, please describe:

1) How the proposed use will not seriously interfere with uses on adjacent property, with the character of the area, or with the purpose of the zone.

2) How the proposed use will not impose an undue burden on any public improvements, facilities, utilities, or services available to the area.

3) How the proposed use will not:

   (a) Force a significant change in accepted farm or forest practices on surrounding landsdevoted to farm or forest use; and

   (b) Significantly increase the cost of accepted farm or forest practices on surrounding lands devoted to farm or forest use.

4) Any special measures you propose to undertake in order to minimize the impacts on adjacent properties and public services, and to ensure compliance with the purpose of the zone. Consider such features as: location of the use on the parcel; road capacities in the area; driveway location; parking area; on-site traffic circulation; landscape or fencing separations; size of structures; signs; exterior lighting; noise; air emissions; drainage.

**Additional Information Needed:**

**Note:** *You may identify more than one person at a time who is in need of the medical hardship, but they must be the property owner or an immediate relative of the property owner(s).*

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 4**).
- ☐ Signed "Authorization to Use or Disclose Health Information" form (**see page 5**).
- ☐ 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 drainfield, driveway, setbacks, etc.). Label all tax lots.

**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(s) 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 will be required recognizing resource use on adjacent farm or forest lands.

***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.*

**Signature(s)**

I hereby certify that I am the legal owners(s) or contract purchaser of the above noted property; that the information contained herein is true and accurate to the best of my knowledge; and that the requested conditional use permit will not violate any deed restrictions attached to the property.

_____ _____

Owner/Contract Purchaser Signature Date

_____ _____

Owner/Contract Purchaser Signature Date

*For Office Use Only*

Application Submitted:_____ Staff Received:_____ File Number: LU-_____

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:

_____