UNION COUNTY
Planning Department

Inga Williams
Planning Director

1001 4th Street, Suite C La Grande, OR 97850 • Phone (541) 963-1014 • www.unioncountyor.gov
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TEMPORARY MEDICAL HARDSHIP (TMH) DWELLING – LAND USE APPLICATION

Please complete & return this form with ATTACHMENTS

Property Owner Name(s)	
Map & Tax Lot & Account ID	
Property Address	
Phone Number	
Email Address	
Mailing Address or N/A	

MEDICAL HARDSHIP INFORMATION

Name of the person needing care	
Who else will be residing with the person needing care	
Name of caregiver	
Relationship of the caregiver to the person needing the care.	

Caregiver will: How many other people will reside with the Caregiver_____

☐ reside in the temporary dwelling
☐ reside in the permanent dwelling

TEMPORARY DWELLING INFORMATION. The temporary dwelling will be a:

☐ Manufactured Home. (Initial acknowledgements below)
_____ I acknowledge that the home will be ☐ Removed or ☐ Demolished when the TMH ends
_____ I acknowledge the home must utilize same sewage disposal system as permanent residence

☐ An existing accessory structure made into a residential use. After TMH ends, this structure will be:
☐ Removed ☐ Demolished ☐ Returned to nonresidential use

☐ Recreational Vehicle (Initial acknowledgement below)
_____ I acknowledge that the RV will be ☐ Removed or ☐ Demolished when the TMH ends

I hereby certify that I am the legal owner of the subject property; and, that the information and justification submitted are in all respects true and accurate to the best of my knowledge and belief.

Landowner

Name

Signature Date

Landowner

Name

Signature Date

I hereby certify that I am the caregiver and that the information and justification submitted are in all respects true and accurate to the best of my knowledge and belief.

Caregiver

Name

Signature Date

ATTACH

1) Vicinity map marked Exhibit A
2) Detailed site plan marked Exhibit B, see Site Plan Example available on Planning Department webpage
3) Any statements of explanatory information to support your request
4) Primary Care Provider Certification

For Planning Department Purposes Only

Date of Submittal _____
Date Considered Complete _____
Application Number _____
Payment Receipt Number _____

For Your Information

This use requires a public hearing in front of the Planning Commission. The hardship needs to be for either:

- A resident of the property who needs care and the care giver must be a relative of the resident, or
- A relative of a resident of the property. The resident needs to be the care giver.

You can convert an existing structure on your property into a dwelling, or use a Recreational Vehicle or Manufactured Home.

This use is **temporary**. Once approved, it is viable for the term of the hardship but when it is no longer needed, the dwelling needs to be removed or converted to an allowable use.

The temporary dwelling needs to use the same sewage disposal system used by the existing dwelling.

If approved, it needs to be re-authorized (by the Planning Department) every two years. You will need to certify that the person with the medical hardship is still living and still requires care.

If the person with the medical hardship no longer requires care before the two years, you will need to provide the Planning Department with notice that the use is no longer required and remove the medical hardship dwelling.

Items to include with the application

- Medical certification from a licensed medical practitioner.
- Site plan showing all existing structures on the property along with the location of the temporary dwelling.
- Identify the name of the person with the medical hardship and who the caretaker will be, and the relationship between them. Identify who else will be living with the person with the medical hardship.

Identify who will be living in what structure. Usually, the person with the medical hardship lives in the temporary dwelling but sometimes the caretakers utilize that structure instead. There is no rule requiring who lives where

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TO: Primary Care Provider

RE: Temporary Medical Hardship Dwelling

You are being asked to verify that a medical hardship exists with your patient. A medical hardship may enable your patient to live in a second, temporary, dwelling alongside a relative who can provide them with daily care. Your patient must have an illness or infirmity serious enough to require this person to, otherwise, be housed in a care facility. This means that the impairment renders them incapable of maintaining a separate and detached residence on a separate property and that they require daily care. Daily care includes, but is not limited to, bathing, grooming, eating, medication management, walking and transportation.

The infirmity must be a physical or mental impairment. Financial hardship, childcare, upkeep of home or property, or other convenience arrangements are not considered infirm conditions and will not qualify for approval of a temporary medical hardship permit.

Please complete the attached Medical Certification form. You may be asked to provide additional written or oral testimony to the County's Planning Commission to verify the patient's condition.

Thank you for your assistance.

Sincerely

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PRIMARY CARE PROVIDER CERTIFICATION OF MEDICAL HARDSHIP

Union County provides landowners an opportunity to request temporary establishment of a secondary dwelling as a conditional use permit for themselves or a relative with a medical hardship relating to the aged or infirm. Approval is specific to the patient and applicant's relative caregiver. Approval is not transferrable to other patients, caregivers, or properties.

To Patient's Primary Care Provider:
Your patient is requesting certification that they are aged or infirmed and that the patient's existing medical condition:

1. Requires assistance by a relative caregiver living on the property in a separate dwelling
2. Would otherwise require care at a residential facility

PATIENT & CAREGIVER INFORMATION	
Patient Name, DOB	
Relative Caregiver Name	
Relation to Patient	

The patient suffers from ☐ Medical-related condition ☐ Age-related condition
Describe the general medical or age-related condition(s) that requires assistance from the relative caregiver living on the property in a separate dwelling that would otherwise require care at a residential facility

Daily activities that require assistance so frequently or in such a manner that the caregiver must reside on the same parcel *(check all that apply; add if not listed)*

☐ Supervision ☐ Dressing ☐ Ambulation / Transferring ☐ Shopping Bathing /Grooming
☐ Laundry ☐ Toileting ☐ Medication Administration ☐ Medical Management
☐ Eating ☐ Shopping ☐ Food Preparation
☐ Other Daily Activities (please describe)

My patient's medical condition prevents him/her from providing basic self-care and requires assistance so frequently or in such a manner that the relative caregiver must reside on the same parcel. I hereby certify that I am the Primary Care Provider for the patient named above and that statements made herein are true and correct to the best of my knowledge.

Signature of Primary Care Provider **Date**

Primary Care Provider Name	
Medical Facility Name	
Primary Care Provider Address	
Primary Care Provider Email	
Primary Care Phone	