UNION COUNTY
Planning Department

Inga Williams
Planning Director

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TEMPORARY MEDICAL HARDSHIP (TMH) DWELLING LAND USE APPLICATION

Submission Date:_____

Applicant

Name(s)	
Phone Number	
Email Address	
Mailing Address	

Owner ☐ same as applicant

Name(s)	
Phone Number	
Email Address	
Mailing Address	

Township	Range	Section	Tax Lot	Zoning Designation	Acreage	Tax Assessor's Ref. No.

Situs address or N/A

_____

Medical Hardship Information

Name of the person needing care	
Relationship of the person needing care to the property owner	
Who else will be residing with the person needing care	

Name of caregiver	

Caregiver will:

☐ reside in the temporary dwelling

☐ reside in the permanent dwelling

How many other people will reside with the Caregiver _____?

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

[Only check one of the following if the property is zoned for resource use]

☐ Existing accessory structure converted to a residential use. (Initial acknowledgement below)

_____ I acknowledge that 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 when the TMH ends

Required Attachments

1) A vicinity map showing the subject property and surrounding roads and adjacent properties.
2) A site plan, see attached example.
3) A copy of the latest deed.
4) Primary Care Provider Certification
5) Any statements of explanatory information to support your request

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

Landowner Signature			*Landowner* Signature	
Printed Name	Date		Printed Name	Date

Include an attachment with additional signatures if the above spaces are not sufficient.

I hereby certify that I will be 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 Signature	
Printed Name	Date

For Planning Department Purposes Only

Date Considered Complete _____

Payment Receipt Number _____

Application Number _____

For Your Information

This use requires a public hearing in front of the Planning Commission.

The caregiver does not need to be related to the person requiring care.

The person needing care must be a resident of the property or a relative of a resident of the property.

There is no rule requiring who lives in the temporary hardship structure.

If your property is in a Rural or Farm Residential zone you may only use a manufactured home as for the temporary dwelling. If you are in farm or forest zone, 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 back to a nonresidential use.

The temporary dwelling needs to use the same sewage disposal system used by the existing dwelling. This will require a septic authorization from the Harney County Onsite Septic Program.

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.

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TO: Primary Care Provider

RE: Temporary Medical Hardship Dwelling

You are being asked to certify that your patient has a medical condition or conditions related to infirmity or age. A medical hardship certification will enable your patient to gain approval of a temporary dwelling, which will allow them to house a person who can provide them with 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 a medical condition 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 condition relating to the aged or infirm. This certification is specific to the one patient identified below.

To Patient's Primary Care Provider:
Your patient is requesting certification that they have a medical condition related to aged or infirmity and that the patient:

1. Requires assistance from a relative caregiver for daily help
2. Would otherwise require care at a residential facility

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

The patient suffers from ☐ Physical or mental infirmity ☐ Age-related condition

Describe the general medical or age-related condition(s)

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	