UNION COUNTY
Planning Department

Inga Williams
Planning Director

1001 4th Street, Suite C La Grande, OR 97850 • Phone (541) 963-1014 • www.UnionCountyOR.gov
IWilliams@Union-County.org • PTracy@Union-County.org • PHall@Union-County.org

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	Acreage	Tax Assessor's Ref. No.

Zoning Designation: ☐ R-1 ☐ R-2 ☐ R-3 ☐ A-1 ☐ A-2 ☐ A-3 ☐ A-4
☐ Medical Springs-Pondosa Rural Cluster

Situs address

_____

Medical Hardship Information

Name of the person needing care: _____

Is the person needing care already residing on the property? ☐ Yes ☐ No

If No, what is the relationship between the person needing care and a resident of the property?

_____

Who else will be residing in the same dwelling with the person needing care?

_____

Caregiver Information

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 acknowledgement below)

_____ I acknowledge that the home will be £ Removed or £ Demolished when the TMH ends

£ 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 showing all existing structures, septic, well, driveway, and proposed structure.
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 that 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 is a conditional use and 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 and who in the permanent residence.

This use is **temporary**. Once approved, it is viable for the term of the hardship but when it is no longer needed, the temporary hardship structure needs to be removed or converted back to a nonresidential use.

The temporary hardship structure needs to use the same sewage disposal system used by the permanent 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.

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TO: Primary Care Provider

RE: Temporary Medical Hardship Dwelling Patient Certification

You are being asked to certify that your patient has a medical or age-related condition that would require them to be placed in an assisted living facility, nursing home, rehabilitation center, memory care facility or other such facility. You are stating that the patient needs daily care, which includes, but is not limited to, bathing, grooming, eating, medication management, walking and transportation.

If you certify that this type of situation exists, then your patient can apply for a medical hardship dwelling that can provide housing for an on-site caregiver.

The condition must be a physical or mental impairment. A financial hardship, need for childcare, upkeep of home or property, or other convenience arrangements are not considered appropriate reasons to approve a medical hardship dwelling.

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

Inga K Williams

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PRIMARY CARE PROVIDER CERTIFICATION OF MEDICAL HARDSHIP

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 infirmity or age-related debility and that they:

1. Require assistance from a caregiver for daily help, and
2. Would otherwise be required to reside in some type of care facility.

PATIENT INFORMATION

Patient's Name: _____

The patient suffers from £ Physical or mental infirmity £ Age-related debility

Describe the issue(s)

_____

_____

The following daily activities 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)

_____

_____

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	