WASHINGTON COUNTY
Dept. of Land Use & Transportation
Planning and Development Services
Current Planning
155 N. 1st Avenue, #350-13
Hillsboro, OR 97124
Ph. (503) 846-8761 Fax (503) 846-2908
http://www.co.washington.or.us

Application Instructions for: Type II Temporary Use Health Hardship (RENEWAL)

Standards for a Type II Temporary Use Health Hardship Renewal are found in CDC Section 430-135.2. Please review to ensure your request qualifies for the health hardship renewal.

1. **Submit three (3) of each of the following:**

   ☐ **A**. Completed **Type II Temporary Use Health Hardship (RENEWAL) Application** included in this packet, with date and original signature of the property owner.

   ☐ **B.** An accurate **site plan** of the property with the existing dwelling and the temporary dwelling, drawn to scale. The plan shall show flood plain area and elevations, drainage hazard area and elevations, significant natural resource areas, building setbacks, property lines and dimensions, all structures on the property with use identified, location and dimensions of the off-street parking, location and dimensions of all driveways and approaches, distance of the temporary dwelling from the primary dwelling, location of the well, location of the septic drainfield area and its dimensions and all forest structure siting requirements from Section 428 if the property is located in the EFC District.

   ☐ **C.** Completed **Type II Temporary Use Health Hardship (RENEWAL) Supplemental Information** form included in this packet.

   ☐ **D.** Copy of Washington County's **Official Tax Map** that contains the subject property. Available either from Current Planning or online at http://washims.co.washington.or.us.InterMap/

   ☐ **E.** Completed and **current Physician Certification** included in this packet.

   ☐ **F. Signed Pre-application Waiver** form included in this packet.

2. **Pay Fees:** Please refer to the current copy of the Current Planning fee schedule and remit required payment when submitting the application. Checks payable to: *Washington County*.

   Type II Temporary Use Health Hardship Renewal: _____

If you have any questions regarding the Washington County Community Development Code standards or application requirements for a Type II Temporary Use Health Hardship Permit Renewal, please contact **Current Planning at (503) 846-8761.**

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Type II Temporary Use Health Hardship (RENEWAL) Application

CPO: _____ COMMUNITY PLAN: _____

LAND USE DISTRICT: _____

ASSESSOR MAP: _____ **TAX LOT NUMBER(S):** _____

_____ _____

NOTE: *Contiguous property under identical ownership will be reviewed as part of this application and may be subject to conditions of approval. List assessor map and tax lot numbers of all contiguous property under identical ownership:*

_____ _____

_____ _____

SITE ADDRESS: _____

SITE SIZE: _____

CASEFILE #: _____
(to be assigned by Washington County)

APPLICANT:

COMPANY: _____
CONTACT: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____
E-MAIL ADDRESS: _____

APPLICANT'S REPRESENTATIVE: *NOTE: The Applicant's Representative will be the primary contact for the County.*

COMPANY: _____
CONTACT: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____
E-MAIL ADDRESS: _____

OWNER(S): *(attach additional sheets if needed)*

NAME: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____
E-MAIL ADDRESS: _____

ALSO NOTIFY:

NAME: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____

EXISTING USE OF SITE: _____

PROPOSED DEVELOPMENT ACTION: **Renewal** of Temporary Use Health Hardship

We, the undersigned, hereby authorize the filing of this application and certify that the information contained in this application is complete and correct to the best of our knowledge. This also authorizes the designated Applicant's Representative (if applicable) to act on behalf of the Applicant for the processing of the request.

X _____
☐ **OWNER** ☐ **CONTRACT PURCHASER** **DATE**
Print Name: _____

X _____
☐ **OWNER** ☐ **CONTRACT PURCHASER** **DATE**
Print Name: _____

X _____
APPLICANT **DATE**
Print Name: _____

X _____
APPLICANT **DATE**
Print Name: _____

PLEASE NOTE:

- *This application must be signed by ALL the owners or ALL the Contract Purchasers of the subject property.*
- *If this application is signed by the Contract Purchaser(s), the Contract Purchaser is also certifying that the Contract Vendor has been notified*
- *No approval will be effective until the appeal period has expired.*
- *Corporations require proof of signature authority for that entity according to their Articles of Incorporation or as registered with the State of Oregon Corporation Division at http://www.filinginoregon.com*

TYPE II TEMPORARY USE HEALTH HARDSHIP (RENEWAL)
SUPPLEMENTAL INFORMATION FORM

1. The temporary accommodation may be **ONE** of the following. Please mark the appropriate item.

____ A manufactured dwelling; or

____ In the EFU, EFC, AF-20, AF-10 and AF-5 Districts, a recreational vehicle (RV); or

____ In the EFU, EFC, AF-20, AF-10 and AF-5 Districts, the residential use of an existing building on a lot or parcel with a Dwelling Unit

2. The temporary accommodation is necessary to provide adequate and immediate health care to **ONE** of the following.

____ The existing resident (name of individual):_____

____ Relative of the existing resident (name of individual):_____

____ Except in the INST, IND, EFU, EFC or AF-20 Districts, a non-relative of the resident who is dependent upon the resident for day-to-day care. **Who is the person needing care and what is the relationship of the person to the applicant?**_____

_____

_____

3. As used in Section 430-135.2 for Temporary Use Health Hardships, "care" means assistance, required as a result of age and/or poor health, that is given to a specific person in the activities of daily living, which may include but are not necessarily limited to, bathing; grooming; eating; medication management; ambulation and/or transportation; and/or daily supervision when such supervision is required due to cognitive impairment. **Please mark all forms of care that apply.**

____ Activities of daily living such as bathing, grooming, eating and/or medication management

____ Ambulation and/or transportation

____ Daily supervision required due to cognitive impairment

NOTE: "Care" does <u>not</u> include assistance with improvement or maintenance of property unless a documented need for assistance with personal activities or a need for personal supervision due to cognitive impairment exists. "Care" does <u>not</u> include financial hardship alone.

4. Please explain why the circumstances that provided the basis upon which the previous permit was granted remain substantially similar._____

_____

_____

_____

_____

_____

_____

_____

_____

5. Please initial and complete each of the following:

____ I understand the permit period shall not exceed twenty-four (24) months, unless the hardship permit is renewed.

____ I understand in the case of a manufactured dwelling or park model recreational unit, the proposed structure is to be vacated and removed within three (3) months of the end of the hardship, or upon expiration of the specified time limit in the development period.

____ I understand in the case of an existing building, the building shall be removed, demolished or returned to an allowed nonresidential use within three (3) months of the end of the hardship period.

____ I understand this permit shall not be transferable to anyone other than the individual named herein who requires assistance with care.

____ The property owner has executed a restrictive covenant which sets forth the requirements of Section 430-135.2 A. (7). **Please list the instrument number of the recorded restrictive covenant.**_____

____ I understand all necessary services, such as water, natural gas and/or sanitary sewer, for the temporary accommodation shall be extended from the permanent dwelling services. The temporary accommodation shall be allowed to have a separate electrical meter. However, no other separate utilities shall be allowed.

____ I understand the temporary accommodation shall use the same driveway entrance as the permanent dwelling, although the driveway may be extended. An exception may be granted if more than one lawfully established driveway entrance exists.

____ I understand the temporary accommodation shall be located within 100 feet of the permanent dwelling as measured from the closest portions of each structure. The distance may be increased if the applicant provides evidence substantiating why compliance with the standard is not possible.

____ I understand a temporary residence approved under this Section is <u>not</u> eligible for a replacement dwelling under Section 430-8 of the Code.

____ I acknowledge that this Health Hardship Renewal is for the same individual for whom the initial Health Hardship was obtained. **Please list the name of the individual for the original Health Hardship.**_____

6. Explain how/why the use has not had an adverse effect on the neighborhood. _____

_____

_____

_____

_____

7. Acknowledgement and Signature:

I, _____, acknowledge that my signature affirms that the information submitted above, along with all attachments, is true and accurately reflects the request for a Temporary Use Health Hardship Renewal.

_____ _____

Signature **Date**

WASHINGTON COUNTY PRE-APPLICATION CONFERENCE WAIVER

"STATEMENT OF UNDERSTANDING"

The Washington County Department of Land Use and Transportation staff, pursuant to Section 203-2.1B of Ordinance 264 Washington County Community Development Code, is required to meet and confer with prospective applicants to discuss the requirements for formal applications for land use actions. For this purpose a scheduled appointment (pre-application conference) may be reserved with the staff on a first come-first served basis throughout the year. At this meeting applicants may discuss their proposal with staff and ask questions regarding the feasibility of approval.

As an alternative, Section 203-2.1B also allows applicants to forego this formal process and proceed with only the benefit of the instructions included on the forms as briefly explained by staff, without the benefit of a pre-application conference. The applicant recognizes that he/she is solely responsible for submitting a complete application being aware that upon failure to do so, the staff has no alternative but to reject it until it is complete or to recommend the request for denial regardless of its potential merit.

I have read and understand the above statement.

Tax Map: _____ Tax Lot(s): _____

APPLICANT: _____

_____ _____

APPLICANT'S SIGNATURE DATE

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Physician Certification
(Physician: See instructions to right)

Instructions to Physician: Please return this form to the patient (listed below).

Patient's Name: _____
Patient's Mailing Address: _____
_____
_____
Patient's Phone Number: _____

This form must be completed and signed by the health hardship dwelling candidate's physician and submitted with the application for a temporary health hardship dwelling.

1. Patient's Name: _____

The above named person is applying to Washington County for approval to occupy a temporary health hardship dwelling, or is renewing an already approved temporary dwelling. If approved, this permit is valid for a two-year period.

A temporary health hardship may be allowed when a patient suffers from a health or age-related infirmity (either a physical or mental impairment) that renders him/her incapable of maintaining a residence on a separate property, and requires a caregiver's close physical proximity on a daily basis to provide care. The need for care is defined as the need for assistance with the activities of daily living—such as bathing, grooming, eating, medication management, ambulation and transportation. The need for care may also include the need for supervision required due to cognitive impairment. ***INABILITY TO MAINTAIN PROPERTY IS NOT A VALID REASON FOR A TEMPORARY HEALTH HARDSHIP.***

In order to process this application, the patient's attending licensed physician MUST certify that a health or age-related infirmity exists, and describe how the impairment requires someone close by to provide assistance.

2. AS THE ATTENDING PHYSICIAN, I CERTIFY THE ABOVE-NOTED PATIENT REQUIRES CARE AS DESCRIBED ABOVE? YES _____ NO _____ OTHER _____

WILL THIS PATIENT ALWAYS REQUIRE CARE? YES _____ NO _____ OTHER _____

In non-technical language, please state the nature of the infirmity:_____

_____

Please explain how the infirmity limits the patient from maintaining a residence on a separate property, and requires a caregiver in close physical proximity to provide care: _____

_____

3. Print Physician's Name: _____

Medical License No.: _____

Physician's Signature: _____

Address: _____

City: _____ State: _____

Zip: _____ **Date (Required):** _____

Phone: _____