

MEDICAL HARDSHIP DWELLING APPLICATION

PROPERTY & APPLICATION INFORMATION

ASSESSOR'S LEGAL DESCRIPTION:

TWN _____ RNG _____ SEC _____ QQ _____ TAX LOT _____

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PROPERTY ADDRESS: _____

EXISTING ZONING: _____ PARCEL SIZE: _____

NATURE OF DISABILITY: _____

CARE PROVIDER'S NAME: _____

WILL OUTSIDE ASSISTANCE BE USED: _____ IF YES, HOW OFTEN AND WHO: _____

NAME & RELATIONSHIP OF DEPENDENT PERSON: _____

MAILING ADDRESS: _____

TYPE OF DWELLING (RV, MANUFACTURED DWELLING, CONVERSION OF EXISTING STRUCTURE):

IF AN EXISTING STRUCTURE IS BEING CONVERTED, PLEASE DESCRIBE THE CURRENT SIZE, USE AND THE PROPOSED MODIFICATIONS: _____

OWNERSHIP & APPLICANT INFORMATION

OWNER'S NAME: _____ TEL: _____

MAILING ADDRESS: _____

CARE PROVIDER'S NAME: _____ TEL: _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____

APPLICANT'S STATEMENT OF UNDERSTANDING

I, _____, have filed an application for a **MEDICAL HARDSHIP DWELLING** with the Community Development – Planning Division to be reviewed and processed according to state and county requirements. My signature below affirms I have discussed my application with planning staff, and that I acknowledge the following disclosures:

1. I understand that any representations, conclusions or opinions expressed by staff in the pre-application review of this request do not constitute final authority or approval, and that I am not entitled to rely upon any such expressions in lieu of formal approval of my request.
2. I understand I may ask questions and receive input from the planning staff, but acknowledge that I am ultimately responsible for all information or documentation submitted with this application. I further understand the Planning Staff cannot legally bind the county to any fact or circumstance which conflicts with state or local laws, and in the event a conflict occurs, the statement or agreement is void.
3. I understand it is my responsibility to show my request meets code requirements, and I must provide all of the required documentation or information necessary to justify a permit. The standards for approving or denying my request for a **MEDICAL HARDSHIP DWELLING** have been furnished to me as part of this application. The medical hardship does not automatically transfer with the property.
4. I understand the planning staff is entitled to ask for additional information or documentation any time after the submission of this application if it is determined such information is required for review and approval.
5. I understand the processing of my application may require a site visit, which may include officials from other agencies, and photographs are commonly taken. Advance notice of the visit will be provided when the site is also a personal residence.

Date: _____

OWNER (*Owner signatures must be notarized*)

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DEPENDENT PERSON

CARE PROVIDER

MEDICAL HARDSHIP DWELLING

The Medical Hardship dwelling permit process allows the establishment of a second dwelling for use in the care of a dependent family member or friend. The medical hardship dwelling can be a manufactured dwelling, a recreational vehicle or a converted building. The medical hardship dwelling is temporary and can be used only as long as the medical hardship continues. A physician's statement establishing the disability and the need for on-site care is an absolute requirement for the permit. The permit must be renewed annually including a new physician's statement for **temporary conditions** and verification of septic capacity from the DEQ.

A "dependent person" is any person who suffers from a mental or physical disability so that on-site assistance is required to establish a non-institutional residence. A "care provider" is any person or persons who agree to assist a dependent person in residential living. The care provider may be the owner, a renter, or the applicant for the second dwelling. If the care provider or applicant is someone other than the owner, the owner must also sign the application.

A *Development Permit* is issued once the planning office determines all of the required documentation and forms are complete. Notification of the neighborhood is not required, and the issuance of a medical hardship dwelling permit cannot be appealed.

APPLICATION REQUIREMENTS

GENERAL PROCEDURES

1. Obtain a *Medical Hardship Dwelling Application* from the Planning Office. Complete the front page of the application and the *Applicant's Statement of Understanding*. The Owner, Care Provider, and Dependent Person must all sign the application. If you are unsure about any of the required information, please talk with a Planner.
2. Complete an accurate *Plot Plan* (drawing) of your property, showing location of the residence and the proposed medical hardship dwelling (the required form is attached to this application).
3. Take the completed *Doctor Certification* form to your **Oregon** licensed **MD, DO or NP** who provides information regarding the illness or disability and have him/her sign the form (the required form is attached to this application).
4. Complete the *Grant of Deed Restriction - Restriction of Uses*. The deed restriction use is a notarized statement that must be filed in the county's deed records for the property involved in this application, and **must** be signed by the owner. The purpose is to create a legal disclosure that the medical hardship dwelling is a temporary dwelling only and must be removed or converted when the hardship ends.
5. Submit your completed application materials to the **Planning Office** with the required fee of **\$325.00**.
6. Once a Planner determines the application meets the ordinance requirements, a *Development Permit* is issued for a fee of **\$300.00**. After the application is complete, (*Application, Applicant's Statement of Understanding, Plot Plan, Physician's Certificate, Grant of Deed Restriction - Restriction of Uses*), the Planner processes the Development Permit. The Development Permit includes all property & proposal information. The applicant takes the issued Development Permit to the following agencies for their sign-off:
 7. Take the *Development Permit* to the **DEQ** for a septic permit, and to **Building Safety** for a placement permit (plumbing, electrical and setup). Additional fees may apply.
 8. Applicant returns a copy of **Building Safety** and **DEQ** signatures to Planning.
 9. If a manufactured dwelling is the medical hardship dwelling, please contact the **Assessor's Office** for information regarding trip permits, ownership documents, and property taxes.

43.040 - ANNUAL RENEWAL

Unless specified in the Article otherwise, all temporary use permits shall be reviewed annually by the Planning Director. A decision to renew a temporary use permit shall be processed using the review procedures as set forth in Article 22 of this Code. Annual renewals shall be governed by the following standards:

1. Annual renewals shall occur as close as practical to one calendar year from the date of issuance of the permit, but the Planning Director is authorized to collect and process renewals in groups or by calendar quarters, as may be convenient.
2. An application for renewal of a medical hardship dwelling, at a minimum, must be accompanied by the prescribed fee of \$50.00, a renewal statement from a medical doctor certifying continuance of the incapacity, and a written acknowledgment from the DEQ stating the dwelling continues to be served by an authorized sewage disposal system.
3. If Building Safety and the DEQ approvals are not obtained **PRIOR TO OCCUPANCY**, this approval permit may not be renewed, and a new application required.

DATE: _____ TWN _____, RNG _____, SEC _____ QQ _____, TL _____

OWNER'S NAME: _____

ADDRESS: _____

PLOT PLAN

SIGNATURE: _____



Doctor Certification

For temporary use of a Medical Hardship Dwelling

Legal: _____

Property Owner: _____

I hereby certify that I am the licensed physician for _____

The above named person is applying to Josephine County for approval to occupy a temporary dwelling on the above property, or is renewing an already approved temporary medical hardship. A temporary dwelling is permissible for patients who suffer from a physical or mental infirmity. The infirmity must render them incapable of maintaining a complete, separate, and detached residence on a separate property and requires someone to be close by to assist them.

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.

In order to process this application, it is necessary that the patients' attending licensed physician certify that a physical or mental infirmity exists.

DOES THIS PATIENT REQUIRE CARE AS DESCRIBED ABOVE? YES NO

I certify that this person has a medical or physical hardship that requires care and attention in the fashion described above, and the named patient should be permitted to reside near a caretaker in order to facilitate proper care:

Print Doctor's Name: _____

Place Medical Office Stamp Here

Medical License # _____ State _____

Doctor's Signature: _____

Date: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Must be an **Oregon** licensed **MD, DO or NP.**

INFORMATION CONTAINED ON THIS FORM IS PUBLIC INFORMATION PURSUANT TO ORS 192.420

Applicant:

Please note that the attached **GRANT OF DEED RESTRICTION - RESTRICTION OF USES** must have a formal legal description of the property attached to it as *Exhibit A*. The legal description may be obtained from your deed, a title company, or the Assessor's Office. The legal description must be copied onto a separate sheet of paper, marked as "*Exhibit A*," and then attached to the deed restriction. After the Medical Hardship application is approved, the deed restriction, together with *Exhibit A*, must be recorded in the deed records in the County Clerk's Office, and a conformed copy returned to the Planning Office who will issue your *Development Permit*. If you have any questions, please contact our office at (541) 474-5421.

RECORDER'S USE

Grantor's Name and Address

Grantee's Name and Address

GRANT OF DEED RESTRICTION - RESTRICTION OF USES

Grantor(s), _____, and Josephine County, a political subdivision of the State of Oregon, by and through its Planning Director, on this _____ day of _____, 20_____, do hereby covenant and restrict for good and valuable consideration, including consideration other than money valued at \$1.00, regarding the use of certain real property described in the Assessor's records as T_____, R_____, Sec. _____ -- _____, Tax Lot _____, and as more particularly described in Exhibit A. The following declarations, restrictions and conditions are given and received in exchange for a permit to place a second dwelling on the described property for the temporary duration of a medical hardship:

1. The second dwelling located on the real property is authorized as a medical hardship dwelling pursuant to Article 43 of the Rural Land Development Code (RLDC). The second residence is temporary in duration and the permit must be renewed annually.
2. Section 43.030.A.2.h of the RLDC provides that the permit for the second dwelling shall terminate 90 days after the condition or occasion giving rise to the hardship ceases to exist, or the owner fails to renew the permit as required by Section 43.040 of the RLDC. Therefore, pursuant to Section 43.030.A.2.i of the RLDC, Grantor(s) covenant that within 90 days from the termination of the medical hardship permit the second dwelling shall be removed from the property, or converted to an approved accessory structure.
3. Pursuant to Section 43.030.A.2.g of the RLDC, Grantor(s) hereby grant the Planning Director, or agents under the authority of the Planning Director, permission to inspect the property and hardship structures to determine compliance with the covenants and restrictions contained in this agreement. Inspections shall only occur after the planning office provides advance telephone or written notice to the owner or tenant, whoever is in possession. Telephone notice shall be accomplished by personal telephone contact with the owner or tenant, whoever is in possession, at least 48 hours prior to the inspection. Written notice shall be accomplished by mailing to the owner or tenant, whoever is in possession, at least 7 days prior to the inspection. Written notices shall be mailed to the last known address in the Planning Director's file, or if an address is not known, to the address shown in the Assessor's records.
4. Within 90 days from the termination of the hardship permit, Grantor(s) agree to apply for and obtain a Certificate of Compliance as described in Section 43.030.A.2.i and j of the RLDC. In exchange, the Planning Director covenants to promptly verify compliance and issue a Certificate of Compliance to Grantor(s). The Certificate of Compliance shall reconvey and terminate any and all rights granted to Josephine County under this instrument.

THIS INSTRUMENT WILL NOT ALLOW USE OF THE PROPERTY DESCRIBED IN THIS INSTRUMENT IN VIOLATION OF APPLICABLE LAND USE LAWS AND REGULATIONS. BEFORE SIGNING OR ACCEPTING THIS INSTRUMENT, THE PERSON ACQUIRING FEE TITLE TO THE PROPERTY SHOULD CHECK WITH THE APPROPRIATE CITY OR COUNTY PLANNING DEPARTMENT TO VERIFY APPROVED USES AND TO DETERMINE ANY LIMITS ON LAWSUITS AGAINST FARMING OR FOREST PRACTICES AS DEFINED IN ORS 30.930.

Josephine County

Grantor(s)

Planning Director

STATE OF OREGON, County of _____ } ss.
On this _____ day of _____, 20_____, _____, personally came before me, a Notary Public for the State of Oregon and the County of Josephine, and executed the above *Grant of Deed Restriction - Restriction of Uses* and acknowledged to me that it was freely and voluntarily done.

NOTARY SEAL

Notary Public of Oregon
My commission expires _____



Josephine County, Oregon

Community Development – Planning Division

700 NW Dimmick, Suite C / Grants Pass, OR 97526

(541) 474-5421 / Fax (541) 474-5422

E-mail: planning@co.josephine.or.us

PRIOR TO OCCUPANCY, both DEQ and Building Safety approvals must be obtained. A copy of this signed form must be returned to the Planning Office before the annual renewal or your permit may be revoked.

Date: _____

Property Owner(s): _____

Property Address: _____ Legal # _____

Note to Department of Environmental Quality (DEQ) & Building Safety:

Please sign off below when the property owner has obtained the required permits from your department.

Department of Environmental Quality

221 Stewart Avenue, Ste. 201, Medford, OR 97501

541-776-6214

The property owner has completed the septic requirements for DEQ (*please attach a copy of your permit for our files*).

Not applicable: _____ Separate System _____ Large System _____ On Sewer

DEQ Signature

Date

Building Safety

700 NW Dimmick Street, Ste. A, Grants Pass, OR 97526

541-474-5405

The property owner has completed the building requirements for Building Safety.

Building Safety Signature

Date



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OPTIONS WHEN A MEDICAL HARDSHIP IS NO LONGER NEEDED

1. Remove medical hardship dwelling from the property. This requires an inspection by the Code Enforcement Administrator (541-474-5425) once it is removed.
2. Convert the medical hardship dwelling to an accessory living structure. This requires removal of kitchen, inspection by Code Enforcement Administrator (541-474-5425). You must contact DEQ (541-776-6214) and Building Safety (541-474-5405) for any additional permits.
3. Convert the medical hardship structure to a temporary storage of unoccupied manufactured dwelling. This requires a development permit. The development permit is good for only 6 months and the Planning Director may renew for only one more additional 6 month period.
4. Replace the dependent person. This requires a new physician certificate to be filed with the Planning Office. You obtain this form from the Planning Office.
5. The medical hardship does not automatically transfer with the property as specific criteria must be met.

Per Rural Land Development Code 43.030- Permitted Temporary Uses:

A. Medical Hardship Dwelling

2. Standards

- h. The Temporary Use Permit for a medical hardship dwelling **shall terminate 90 days** after the care-giving relationship between the dependent person and the care provider ceases for any reason, or **90 days** after the property owner fails to renew the permit as required.

**If you have additional questions,
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SELLING A PROPERTY WITH A TEMPORARY MEDICAL HARDSHIP DWELLING

If you plan to sell your property, it is **your** responsibility to call Planning and close the temporary medical hardship and bring the property into compliance **before** closing on the sale of the property. The temporary medical hardship cannot be passed on to a person buying the property from you. If the property is not brought into compliance before you sell, then you create a land use violation for the new owner.

Here are the steps to follow when closing your temporary medical hardship and bringing the property into compliance:

1. Call Planning and close the temporary medical hardship.
2. **You** have 90 days to either remove the medical hardship dwelling or convert it by removing the entire kitchen and calling the Code Enforcement Administrator at 541.474.5425 to schedule and inspection.
3. Once the inspection is complete you will receive a Verification of Compliance form. Take this form to the County Clerk's Office to record and have the Grant of Deed Restriction removed.

I acknowledge that I have read and I agree to follow the steps listed above when I no longer need the temporary medical hardship and/or I sell this property.

Owner/Date

Owner/Date

*Original for Planning – copy to applicant

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