

# TEMPORARY HARDSHIP DWELLING RENEWAL

**Yamhill County**  
**DEPARTMENT OF PLANNING AND DEVELOPMENT**  
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|           |                 |
|-----------|-----------------|
| Docket    | _____           |
| Date      | _____           |
| Rec'd by  | _____           |
| Receipt # | _____           |
| Fee       | <b>\$160.83</b> |

ORIGINAL DOCKET NO.: \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

TELEPHONE: Home \_\_\_\_\_ Work \_\_\_\_\_ E-Mail: \_\_\_\_\_

TAX LOT NO.: \_\_\_\_\_ Site Address: \_\_\_\_\_

OWNER'S NAME (if different from above): \_\_\_\_\_

1. Name of person with hardship: \_\_\_\_\_

2. Relationship of person with hardship to property owner: \_\_\_\_\_

3. Name of caregiver(s): \_\_\_\_\_

4. Justification that hardship conditions exist. (**Attach a letter from a doctor or provide evidence that the person with the hardship is aged, infirm, or for health-related reasons, cannot maintain a complete separate residence. If aged, 70 years of age and above, you may provide copy of a driver's license or copy of a birth certificate instead of the letter from a doctor.**)

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

I understand that issuance of a permit based on this application will not excuse me from complying with effective ordinances and resolutions of Yamhill County and Oregon Revised Statutes despite any errors on the part of the issuing authority in checking this application.

I hereby grant permission for and consent to Yamhill County, its officers, agents and employees, coming upon the above-described property to gather information and inspect the property whenever it is reasonably necessary for the purpose of processing this application.

\_\_\_\_\_  
Signature of person with hardship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner's Signature

\_\_\_\_\_  
Date

# PHYSICIAN'S CERTIFICATE

As set forth below, the Yamhill County Zoning Ordinance provides for the placement of a manufactured home as an additional home-site when certain hardship conditions exist.

## *Temporary Use of a Manufactured Home or an Existing Building for the Term of Hardship*

The use of a manufactured home on a temporary basis during a family hardship condition may be approved as a Conditional Use. A permit may be granted for a period of not more than two years and may be renewed for successive periods of two years if evidence is provided that the hardship condition relates to the aged, the infirm, or to persons otherwise incapable of maintaining a complete separate residence apart from their family, and also whether the requested use will be relatively temporary in nature. It is not the intent of this provision to subvert the intent of the underlying zoning district by permitting more than one permanent residence on each property. In granting the request for temporary use of a manufactured home, conditions are imposed that will preclude the possibility of such temporary use becoming permanent. The following Physician's Certificate must be completed and submitted with the temporary hardship conditional use application.

A medical doctor shall sign a statement indicating the physical or mental condition that prevents the person(s) with the hardship from providing the basic self-care needed to live on a separate parcel. The statement shall also attest that the physician is convinced the person(s) with the hardship must be provided the care so frequently or in such a manner that the caretaker must reside on the same premises.

This is to certify that \_\_\_\_\_ is a patient of mine and is physically

(Please print or type name of patient)

handicapped due to \_\_\_\_\_

(Please print or type brief explanation of condition)

It is my opinion that this physical condition requires care and attention and the above-named person should be permitted to reside nearby one who can give aid and comfort when the need arises.

Doctor's Signature: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_  
(Please print or type)

Doctor's Address: \_\_\_\_\_

Doctor's Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_