PINAL COUNTY COMMUNITY DEVELOPMENT

31 N. PINAL ST. BLDG. F, FLORENCE, AZ 85132/520-866-6442

(Incomplete applications will not be accepted)

PINAL COUNTY PROCEDURE FOR SPECIAL DENSITY PERMIT (SDP)

1. Upon receipt of the application and all required documentation, allow a minimum of 30 days for the request to be processed.

2. The applicant will be advised by phone of the decision.

3. If the application is approved, the permit with stipulations will be issued to the applicant. At the same time, a letter will be mailed to all property owners within 300 feet of the subject property advising that a Special Density Permit has been approved for the parcel.

APPLICATION FOR A SPECIAL DENSITY PERMIT FOR A HANDICAPPED/DISABLED CARE DWELLING UNIT IN AN UNINCORPORATED AREA OF PINAL COUNTY, ARIZONA

(ALL APPLICATIONS MUST BE TYPED OR W RITTEN IN INK)

1. THE LEGAL DESCRIPTION OF THE PROPERTY:____

   ____

   ____

2. TAX ASSESSOR PARCEL NO.: ____

3. CURRENT ZONING:________________________ 4. PARCEL SIZE: ________________________

5. THE EXISTING USE OF THE PROPERTY IS AS FOLLOWS: __________________________________

   ____

   ____

6. THE EXACT USE PROPOSED UNDER THIS REQUEST: _____________________________________

   ____

A SDP ALLOW S ONE ADDITIONAL DWELLING UNIT TO BE BUILT OR MOVED ONTO A PARCEL FOR ONE OF THE FOLLOW ING USES:

A) BY A HANDICAPPED/DISABLED PERSON(S) WHO NEEDS ASSISTANCE AND SUPPORT FROM THE FAMILY LIVING IN THE PRIMARY RESIDENCE;
B) BY A FAMILY MEMBER WHO IS PROVIDING CARE, ASSISTANCE AND SUPPORT TO THE HANDICAPPED/DISABLED PERSON(S) IN THE PRIMARY RESIDENCE;
C) BY A HEALTH CARE PROVIDER EXPRESSLY EMPLOYED FOR THE PURPOSE OF PROVIDING HEALTH CARE FOR THE HANDICAPPED/DISABLED PERSON(S) IN THE PRIMARY RESIDENCE.

7. WHICH CATEGORY APPLIES TO THIS APPLICATION? ______________________________________

8. WHAT IS THE RELATIONSHIP OF THE HANDICAPPED/DISABLED PERSON(S) TO THE CARE PROVIDER(S)?

   ____

A SAP CAN BE GRANTED ONLY W HERE THE HANDICAPPED/DISABLED PERSON(S) IS PHYSICALLY OR MENTALLY IMPAIRED AND INCAPABLE OF CARING FOR HIS OR HERSELF. THE INDIVIDUAL(S) MUST BE IN NEED OF SUCH CARE, ATTENTION AND SUPPORT THAT W ITHOUT THE SDP, HIM OR HER WOULD HAVE TO BE CONFINED TO A HEALTH CARE FACILITY.

9. WHAT IS THE AGE OF THE HANDICAPPED/DISABLED PERSON(S)? ____________________________

   PLEASE ATTACH A COPY OF A BIRTH CERTIFICATE OR OTHER VALID MEANS OF AGE DETERMINATION.

10. WHAT IS THE REASON THE INDIVIDUAL REQUIRES CARE? A LETTER FROM A PHYSICIAN, ON OFFICE LETTERHEAD MUST BE INCLUDED SPECIFYING THE SPECIFIC HEALTH PROBLEM REQUIRING THE SDP.

11. WHAT ARE THE TYPE AND USES OF STRUCTURES CURRENTLY ON THE PROPERTY? ________________

    ____

    ____

12. WHAT TYPE OF DWELLING UNIT, FOR THE HANDICAPPED/DISABLED PERSON(S), IS TO BE USED ON THE PARCEL? MANUFACTURED HOME_______ SITE BUILT STRUCTURE ________

RECEIPT #	AMT	DATE	CASE

THE APPLICATION MUST PROVIDE SUFFICIENT INFORMATION ON THE SEWAGE DISPOSAL SYSTEM SO THE AQUIFER PROTECTION CAN ASSURE ADEQUACY IF THE APPLICATION IS APPROVED.

13. HAVE YOU CONTACTED THE AQUIFER PROTECTION AND RECEIVED TENTATIVE APPROVAL OF THE PROPOSED SANITARY DISPOSAL SYSTEM? YES_________NO ___________

****

AFFIDAVIT

STATE OF ARIZONA COUNTY OF PINAL

I,____, DO HEREBY DECLARE THAT:

1. I AM THE APPLICANT FOR A SPECIAL DENSITY PERMIT FOR THE HANDICAPPED/DISABLED CARE DWELLING UNIT AND THAT THE SECONDARY DWELLING UNIT IS TO BE LOCATED AT:
   ____

2. THE NAME(S) OF THE PERSON(S) WHO WILL RESIDE ON THE PROPERTY AND WHO WILL BE PROVIDING THE NECESSARY CARE ARE: (ATTACH ADDITIONAL SHEETS IF NECESSARY)
   ____

3. I UNDERSTAND AND WILL COMPLY WITH THE CONDITIONS OF THE SPECIAL DENSITY PERMIT, AND I NOR ANY OTHER PERSON, SHALL RECEIVE ANY RENT OR OTHER VALUABLE CONSIDERATION IN RETURN FOR ALLOWING THE RESIDENTIAL USE OF THE SECONDARY DW ELLING UNIT UNDER THE TERMS OF THIS PERMIT. (THIS DOES NOT PRECLUDE THE PAYMENT TO A HEALTH CARE PROVIDER FOR HEALTH CARE SERVICES.)

4. I UNDERSTAND THAT THIS SPECIAL DENSITY PERMIT WILL TERMINATE ONCE THE HANDICAPPED/DISABLED PERSON(S) NO LONGER PERMANENTLY RESIDES ON THE PROPERTY. I UNDERSTAND AND AGREE THAT UPON TERMINATION OF THE PERMIT, IF THE SECONDARY DWELLING IS A MOBILE HOME THE UNIT SHALL BE REMOVED ENTIRELY, IF IT IS A SITE BUILT STRUCTURE THE COOKING FACILITIES SHALL BE REMOVED.

5. THE SECOND SEPTIC SYSTEM (IF NECESSARY FOR THE SECOND DWELLING) SHALL BE REMOVED OR DESTROYED IN ACCORDANCE WITH PINAL COUNTY AQUIFER PROTECTION DIVISION REQUIREMENTS.

____

SIGNATURE OF AFFIDAVIT

Subscribed and sworn before me this ________ day of _________________, 20_____.

Notary Public, ___________________________________
My commission expires: ________________________

IN ADDITION TO THIS APPLICATION YOU WILL NEED TO SUBMIT:

A. A DETAILED SITE PLAN, DRAWN TO MINIMUM SCALE OF 1" = 100', NOT LARGER THAN 11" X 17". THE SITE PLAN MUST INCLUDE THE FOLLOWING:

1. SIZE AND SHAPE OF PARCEL; PROPERTY DIMENSIONS; NORTH ARROW
2. SHOW ADJACENT STREETS, RIGHTS-OF-WAYS, EASEMENTS AND SETBACKS. INDICATE SIZE, PURPOSE AND WHETHER PUBLIC OR PRIVATE
3. LOCATION, SIZE AND USE OF ALL EXISTING AND PROPOSED BUILDINGS. SHOW SETBACKS FROM PROPERTY BOUNDARY LINES AND BETWEEN STRUCTURES
4. DRIVEWAYS AND PARKING AREAS, SHOW ACCESS, DIMENSIONS AND SURFACE MATERIAL EXISTING AND PROPOSED UTILITIES SHOW LOCATION OF LINES, SIZE AND SERVING COMPANY ANY OTHER INFORMATION AS MAY BE APPLICABLE LANDSCAPING, NATURAL FEATURES (I.E.; WASHES) EXCAVATION SITES, ETC

B. PLEASE PROVIDE SUPPORTING INFORMATION, EXPLAINING IN YOUR OWN WORDS THE EXACT AND SPECIFIC NEED FOR THIS SDP. THIS SHOULD BE ON A SEPARATE SHEET OF PAPER.

C. A LIST OF ALL PROPERTY OWNERS WITHIN 300' OF THE SUBJECT PROPERTY BOUNDARY SHOWING NAME, MAILING ADDRESS AND TAX PARCEL NUMBERS. THIS LIST MUST BE OBTAINED WITHIN THE 30 DAYS PRIOR TO APPLICATION SUBMISSION.

D. A MAP OF THE AREA WITH THE 300' BOUNDARY SHOWN. (A TAX ASSESSOR PARCEL MAP IS ACCEPTABLE.)

E. THE NON-REFUNDABLE FILING FEE ACCORDING TO THE FEE SCHEDULE IN TITLE 2, SECTION 2.160.050 OF THE PINAL COUNTY DEVELOPMENT SERVICES CODE. (THE APPLICATION IS NOT CONSIDERED FILED UNTIL THE FEES ARE PAID.)

F. THE "SUBMITTAL CHECKLIST" FOR THE REQUESTED ACTION WHICH IS PAGE 6 OF THIS APPLICATION.

THIS APPLICATION MUST BE SUBMITTED IN PERSON

I CERTIFY THAT I HAVE SUBMITTED ALL OF THE REQUIRED INFORMATION LISTED ABOVE, AND THAT THE INFORMATION IS FACTUAL. I ALSO UNDERSTAND IF THE APPLICATION IS INCOMPLETE UPON SUBMISSION; IT CANNOT BE FURTHER PROCESSED AND MAY BE DELAYED TILL A FUTURE HEARING DATE.

____

NAME OF APPLICANT ADDRESS PHONE NO.

IF THE APPLICANT IS NOT THE LANDOWNER, A NOTARIZED LETTER AUTHORIZING THE APPLICANT TO REPRESENT THE OWNER MUST ACCOMPANY THIS APPLICATION.

____

NAME OF APPLICANT ADDRESS PHONE NO.

ALL NOTICES WILL BE MAILED TO THE APPLICANT.

____

SIGNATURE OF APPLICANT DATE

PROPERTY OWNERSHIP LIST
(REQUIRED FOR FILING ALL APPLICATIONS)

INSTRUCTIONS:

PRINT NAME, ADDRESS, CITY, STATE, ZIP CODE AND TAX PARCEL NUMBER FOR EACH PROPERTY OWNER WITHIN 300 FEET OF THE SUBJECT PARCEL BOUNDARY.

PARCEL NUMBER:	PARCEL NUMBER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

PARCEL NUMBER:	PARCEL NUMBER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

PARCEL NUMBER:	PARCEL NUMBER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

PARCEL NUMBER:	PARCEL NUMBER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

PARCEL NUMBER:	PARCEL NUMBER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

I HEREBY VERIFY THAT THE LIST ABOVE WAS OBTAINED ON THE______DAY OF______________________ 20___, AT THE OFFICE OF_______________________________________, AND IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

____

SIGNATURE DATE

Subscribed and sworn before me this ________ day of ________________, 20_____.

Notary Public, _________________________________

My commission expires: _______________________

(IF ADDITIONAL COPIES OF THIS FORM ARE NEEDED, PLEASE PHOTOCOPY)

(A PRINTOUT FROM A TITLE COMPANY MAY BE USED FOR PARCEL OWNERSHIP INFORMATION HOWEVER, IT MUST BE NOTARIZED)

SPECIAL DENSITY PERMIT CHECKLIST
TITLE 2, SECTION 2.150.310

THE FOLLOWING INFORMATION MUST BE SUBMITTED AS A PART OF THIS APPLICATION FOR A SPECIAL DENSITY PERMIT FOR A HANDICAPPED/DISABLED CARE DWELLING UNIT:

_______ 1. COMPLETE APPLICATION FOR A SPECIAL DENSITY PERMIT.

_______ 2. A SITE PLAN PREPARED AT A MINIMUM SCALE OF 1" = 100'. IF LARGER THAN 11" X 17", THE APPLICANT SHALL SUBMIT A LEGIBLE BACKLINE REDUCTION OF THE SITE PLAN TO A MAXIMUM OF 11" X 17". THE MINIMUM REQUIREMENTS FOR THE SITE PLAN ARE DETAILED ON PAGE 3 OF THIS APPLICATION PACKET.

_______ 3. A NAME LIST, VERIFIED BY THE APPLICANT, MADE WITHIN 30 DAYS PRIOR TO THIS SUBMISSION, OF THE NAMES, MAILING ADDRESSES AND TAX PARCEL NUMBERS OF ALL PROPERTY OWNERS OF PARCELS WITHIN 300 FEET OF THIS PARCEL.

_______ 4. COPIES OF:_____HANDICAPPED/DISABLED PERSON'S BIRTH CERTIFICATE
_____LETTER FROM ATTENDING PHYSICIAN(S)
_____AQUIFER PROTECTION DIVISION APPROVAL
_____SUPPORTING INFORMATION SHEET

_______ 5. SIGNED AFFIDAVIT INDICATING THE WILLINGNESS TO COMPLY WITH ALL REQUIREMENTS OF SECTION 2.150.310.

_______ 6. NON-REFUNDABLE $347.00 FILING FEE FOR A SPECIAL DENSITY PERMIT.

_______ 7. A SIGNED SPECIAL DENSITY PERMIT SUBMITTAL CHECKLIST.

I CERTIFY THAT I HAVE SUBMITTED ALL OF THE REQUIRED INFORMATION LISTED ABOVE. I ALSO UNDERSTAND THAT THIS APPLICATION FOR A SPECIAL DENSITY PERMIT FOR A HANDICAPPED/DISABLED CARE DWELLING UNIT CANNOT BE PROCESSED UNTIL ALL REQUIRED INFORMATION IS SUBMITTED.

SIGNED BY:____ DATE: ________________________

NOTE: IF APPROVED THERE WILL BE A $69.00 ANNUAL FEE, AND AN UPDATED DOCTORS STATEMENT MUST BE PROVIDED.