



## PINAL COUNTY PROCEDURE FOR SPECIAL DENSITY PERMIT (SDP)

1. File application and all required supporting documentation. **NOTE: THE REQUEST CANNOT BE PROCESSED UNTIL ALL REQUESTED SUPPORTING DOCUMENTATION HAS BEEN RECEIVED. SEE PAGE 5 OF THE APPLICATION WHICH IS THE CHECKLIST CONTAINING A LIST OF SPECIFIC DOCUMENTATION.**
2. Upon receipt of the application and all required documentation, allow a minimum of 30 days for the request to be processed.
3. The applicant will be advised by phone of the decision.
4. If the decision is positive, 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 WRITTEN 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 ALLOWS ONE ADDITIONAL DWELLING UNIT TO BE BUILT OR MOVED ONTO A PARCEL FOR ONE OF THE FOLLOWING 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 SUPORT 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 SDP CAN BE GRANTED ONLY WHERE 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 WITHOUT THE SDP, HE OR SHE 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 \_\_\_\_\_ RECREATIONAL VEHICLE \_\_\_\_\_ SITE BUILT STRUCTURE \_\_\_\_\_

RECEIPT #: \_\_\_\_\_ AMT: \_\_\_\_\_ DATE: \_\_\_\_\_ CASE: \_\_\_\_\_

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

13. HAVE YOU CONTACTED THE HEALTH DEPARTMENT AND RECEIVED TENTATIVE APPROVAL OF THE PROPOSED SANITARY DISPOSAL SYSTEM? YES \_\_\_\_\_ NO \_\_\_\_\_

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**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 ORTHER VALUABLE CONSIDERATION IN RETURN FOR ALLOWING THE RESIDENTIAL USE OF THE SECONDARY DWELLING UNIT UNDER THE TERMS OF THIS PERMIT. (THIS DOES NOT PRECLUDE THE PAYMENT TO A HEALTHH 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, THE SECONDARY DWELLING UNIT SHALL BE REMOVED ENTIRELY OR THE COOKING FACILITIES SHALL BE REMOVED.
- 5. THE SECOND SEPTIC SYSTEM (IF NECESSARY FOR THE HARDSHIP MOBILE HOME) SHALL BE REMOVED OR DESTROYED IN ACCORDANCE WITH PINAL COUNTY HEALTH DEPARTMENT REQUIREMENTS.

\_\_\_\_\_  
SIGNATURE OF AFFIDAVIT

SUBSCRIBED AND SWORN TO BEFORE ME \_\_\_\_\_, A NOTARY PUBLIC IN AND FOR THE COUNTY OF \_\_\_\_\_, STATE OF \_\_\_\_\_, ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_\_.

(SEAL)

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

IN ADDITION TO THIS APPLICATION YOU WILL NEED TO SUBMIT:

- A. A DETAILED SITE PLAN, DRAWN TO A 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
  - 5. EXISTING AND PROPOSED UTILITIES  
SHOW LOCATION OF LINES, SIZE AND SERVING COMPANY
  - 6. ANY OTHER INFORMATION AS MAY BE APPLICABLE  
LANDSCAPING, NATURAL FEATURES (I.E.; WASHES) EXCAVATION SITES, ETC.
- B. A "SUPPORTING INFORMATION" SHEET EXPLAINING IN YOUR OWN WORDS THE EXACT AND SPECIFIC NEED FOR THIS SDP. THIS SHOULD BE ON A SEPARATE SHEET OF PAPER AND BE AT LEAST 1/2 A PAGE IN LENGTH, EXPLAINING IN DETAIL THE REASON FOR THIS REQUEST.
- 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 5 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.

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NAME OF APPLICANT	ADDRESS	PHONE NO.
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**IF THE APPLICANT IS NOT THE LANDOWNER, A NOTARIZED LETTER AUTHORIZING THE APPLICANT TO REPRESENT THE OWNER MUST ACCOMPANY THIS APPLICATION.**

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NAME OF APPLICANT	ADDRESS	PHONE NO.
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ALL NOTICES WILL BE MAILED TO THE APPLICANT.

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SIGNATURE OF APPLICANT	DATE
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**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 No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
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Name: \_\_\_\_\_  
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Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

Parcel No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_

I HEREBY VERIFY THAT THE NAME 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

ACKNOWLEDGED BEFORE ME BY \_\_\_\_\_, ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.

(SEAL)

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

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

(A PRINTOUT FROM A TITLE COMPANY MAY BE USED FOR PARCEL OWNERSHIP INFORMATION BUT THIS SHEET MUST BE NOTARIZED)

