County of Sacramento
Office of Planning and Environmental Review (PER)
827 7th Street, Room 225
Sacramento, CA 95814
(916) 874-6141

# Supplemental Application for Use of Mobile Home as Accessory Dwelling for Persons in Need of Care and Supervision

Pursuant to Sections 3.2.2.B, 3.2.5 Table 3.3, I & 3.10.3.H.2 of the Sacramento County Zoning Code.

**Instructions to the Physician:**

You have been asked to provide information in support of an application for a Conditional Use Permit for a mobile home to be installed on a property as a second dwelling for the purpose of providing close care and supervision for the person named on the reverse of this form. Please read the instructions below and complete all the questions/statements listed on the following page.

**Purpose:**

The purpose of existing County Zoning regulations related to "close care mobile homes" is to provide an opportunity for relative or friends to provide care and supervision of an individual who has physical and/or mental conditions such that the person cannot provide for his/her own care, or where the close supervision of prescribed medical treatment is necessary.

It is not the intent of the regulations to allow a second dwelling unit on the property merely for the convenience of friends or family members who are concerned about a person's well-being or as a precautionary measure for a potential medical problem. Similarly, it is not the intent to allow a second dwelling unit when supervision can be accomplished by telephone from another location, or to provide care that can be accomplished by occasional visits (e.g., help with shopping, transportation to doctor, or other similar activities).

The purpose of the questions contained on the reverse of this form is to assist the hearing officer in determining the degree of care needed.

Please remember that "close care mobile homes" are a temporary use and there must be a medical necessity for the care and supervision of the patient.

Control Number: _____ APN: _____

## Declaration in Support Of Hardship

(Please print or type)

I, _____, M.D., declare as follows:

1. That I am a medical practitioner duly licensed to practice medicine in California.
2. That _____, age _____ is a patient under my care and has been under my care since _____.
3. That said, patient is suffering from the following physical or mental disability: _____
   _____
   _____
   _____
4. That the disability of said patient requires immediate supervision and care for the following reasons (check all that may apply)

   ❑ Patient is unable to self-administer prescribed medical treatment.

   ❑ Patient is unable to perform basic domestic chores (prepare food; maintain sanitary living conditions, etc.)

   ❑ Patient is unable to attend to own personal needs (dress self, maintain personal hygiene) without direct assistance.

   ❑ Other (please specify): _____
   _____
5. That the amount and type of care required by said patient as a result of the above disability is as follows. Please indicate frequency of care provided (e.g. several times daily, daily, every few days, etc.).
   _____
   _____
6. That in my opinion, said patient's condition will require supervision and care to continue for the following period of time: _____

I declare, under penalty of perjury, that I have read and understand the instructions printed on Page 1 of this form and that the foregoing responses are true and correct.

Executed at _____, California, on _____.
(City) (Date)

Signature of Physician: _____

Physician Address: _____

_____

Physician Telephone: _____