DEPARTMENT OF DEVELOPMENT SERVICES
1113 Usher Street, Suite 201
Covington, Georgia 30014
Phone: (678) 625-1650

APPLICATION FOR TEMPORARY MANUFACTURED HOME PERMIT (2026)

( ) NEW ( ) RENEWAL Date of First Issuance:_____
Date of Last Renewal:_____

Name of Property Owner:_____

Address of Property Owner:
_____

_____

Phone Number:_____

Address of Property Where Home is Located:_____

_____

Name of Occupants of Manufactured Home:_____

Reason for Temporary Manufactured Home: ( ) Destruction of Dwelling
( ) Construction of Dwelling
( ) Medical Hardship*

*If request is for a hardship, state the circumstances which would result in undo hardship if the manufactured home is not permitted and complete the attached Medical Statement:
_____
_____
_____
_____
_____
_____

Information Concerning the Manufactured Home:

Manufactures Name: _____

Year and Model: _____

Size: _____

I.D. or Serial #: _____

I hereby certify that all the above information is true and correct to the best of my knowledge. I also certify that I am the record owner of the land upon which the aforementioned mobile home is located. I understand that the Newton County Planning Commission, the Newton County Board of Commissioners or their authorized agents have the right to verify any or all of the preceding information concerning the situation or circumstances of the Temporary Manufactured Home permit. I hereby agree to cooperate with the Newton County Planning Commission, the Newton County Board of Commissioners or their authorized agent in any investigation of the facts concerning the above mentioned manufactured home.

_____ _____

Property Owner Date

_____

Staff Only:

Planning Commission Agenda Date:_____

( ) Approved Date:_____

( ) Unapproved Date:_____

****MEDICAL CERTIFICATION STATEMENT****

This form must be completed when requesting a hardship temporary manufactured home permit.

Patient's
Name:_____
_____

Description of Medical Conditions:

_____
_____
_____
_____
_____
_____
_____
_____

Does/will the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs? _____ Yes _____ No

Physician/Practitioner
Signature_____

Date_____

Field of
Specialization:_____
_____

Address_____
_____

Phone
Number_____
_____

Please attach any supporting documentation.