



## CITY OF COLUMBUS

105 N. DICKASON BOULEVARD COLUMBUS, WISCONSIN 53925-1565  
920.623.5900 FAX 920.623.5901 [www.cityofcolumbuswi.com](http://www.cityofcolumbuswi.com)

# APPLICATION FOR ZONING MAP AMENDMENT

**FEES:**

Application: \$500.00

**DEPOSIT:**

Residential, single lot - N/A

Residential, more than 1 lot or up to 5 acres - \$1,000

Commercial, Industrial - \$1,000

**Instructions to Applicant:** To request a change in the Zoning Ordinance, an application for a zoning map amendment must be filed with the City Clerk's Office and a public hearing held before the City's Plan Commission. Normally there are two primary reasons for a change in zoning. One reason is that the zoning ordinance does not comply with the City's Comprehensive Plan; the second is that the activity or use was not addressed or considered at the time the Comprehensive Plan was adopted. The burden of providing substantiating evidence rests with the applicant.

Applications will not be processed unless all required information for the specific application type is submitted and applicable fees are paid. The application deadline is usually 20 working days before the Plan Commission meeting to allow time for staff review and required publishing. **No partial applications will be accepted and final acceptance will be determined by City Staff.**

**Applicant information. Applicant will be invoiced for any additional professional fee costs:**

Name: Prairie Ridge Health Inc

Address: 1515 Park Ave

City: Columbus State: WI ZIP 53925

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cell: 920-382-0378 Email: \_\_\_\_\_

**Property Interest of Applicant:**

( ) Owner

( ) Contract Purchaser

( ) Leasee

(X) Other (please explain) Authorized Representative

\*\*\*\*\*

**Owner information (if different from Applicant):**

Name: Same as owner

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

\*\*\*\*\*



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### Primary contact information:

Name: Matt Yarech

Address: 1515 Park Ave.

City: Columbus State: WI ZIP 53925

Phone: — Fax: —

Cell: 920-382-0378 Email: myarech@prairieridge.health

\*\*\*\*\*

### Location of Property

Address: 1515 Park Ave Tax parcel number: 1508.16

Legal Description (attach additional sheets if necessary):

Lot 1, CSM NO. 6862

See attached CSM

\*\*\*\*\*

Requested Map Amendment: **A narrative or cover letter shall be attached and include the following:**

1. **Information about Subject Property:**

Current zoning of property: RD Rural Development

Current use of property: Ag Field

2. **Information about the requested zoning map change and what use the amendment would allow:**

rezone from RD to B-X3

3. **Reason for the change to the Zoning Map:** to match B-X<sup>3</sup> zoning of adjoining Parcel 1192.01 (hospital lot)

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*Celebrate!*  
COLUMBUS

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#### 4. Site Plan

A Site plan must be attached at a scale large enough for clarity showing the following information:

1. Location and dimensions of the lot showing all easements and all onsite parking.
2. All structures shown, including signs, the distance between all buildings and all front, side and rear setbacks.
3. All off-street parking spaces.
4. The principal buildings on adjacent lots.

\*\*\*\*\*

I certify that all the above statements and plans submitted with this application are true and accurate. I consent to the entry in or upon the premises described in this application by any authorized official of the City of Columbus for the purposes of inspection as may be required by law. I understand I will be invoiced for any additional professional fees generated by this application.

5/6/2025

Date



Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner (if different from Applicant)

(Please complete an application for any zoning changes at the same time the CSM is filed.) Attached narrative if more room is needed

The Certifies Survey requirements are attached.

Please call if you have questions. 920-623-5900

\*\*\*\*\*

I understand that I must comply with all applicable municipal codes and obtain any necessary permits from the Columbus Building Inspector, Zoning Administrator and others; that information submitted with this application is accurate; I agree to pay all fees related to the review of the certified survey map according to City Ordinances (fees and costs for consulting above the fee amount).

Applicant/Authorized Agent Signature\_\_\_\_\_

Property Owner Signature Melissa L. Mangaw on behalf of  
Prairie Ridge Health, Inc.

Property Owner Signature\_\_\_\_\_