STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No: 2011-42679
Issue No: 2009; 4031
Case No: [redacted]
Hearing Date:
October 26, 2011
St. Clair County DHS

ADMINISTRATIVE LAW JUDGE: Vicki L. Armstrong

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon Claimant's request for a hearing. After due notice, a telephone hearing was held on October 26, 2011. Claimant personally appeared and testified.

ISSUE

Whether the Department of Human Services (the department) properly denied Claimant's application for Medical Assistance (MA-P), Retro MA and State Disability Assistance (SDA)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

(1) On April 5, 2011, Claimant filed an application for MA, Retro-MA and SDA benefits alleging disability.

(2) On June 9, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P, Retro-MA and SDA stating that Claimant's physical impairment will not prevent employment for 90 days or more. MRT denied Claimant's MA application stating Claimant is capable of performing other work, pursuant to 20 CFR 416.920(f).

(3) On June 16, 2011, the department caseworker sent Claimant notice that her application was denied.

(4) On June 24, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(5) On August 18, 2011, the State Hearing Review Team (SHRT) again denied Claimant's application stating Claimant retains the capacity to perform a wide of range of simple and repetitive work. (Department Exhibit B, pages 1-2).

(6) Claimant has a history of attention deficit hyperactivity disorder (ADHD), cognitive impaired depression, anxiety, avoidant personality disorder, hypertension, insulin dependent diabetes, dyslipidemia, and alcohol, nicotine and caffeine dependence.

(7) On March 1, 2010, Claimant's doctor discussed obesity, hypertension and dyslipidemia with Claimant and prescribed the Dash diet. (Department Exhibit A, page 24).

(8) On May 5, 2010, Claimant's doctor noted Claimant's alcohol intake had increased and she was noncompliant with her diet. He increased her dosage of Lantus and counseled her regarding obesity and nutrition. Claimant was diagnosed with alcoholism, obesity, hypertension, and a dental infection. (Department Exhibit A, page 23).

(9) On June 30, 2010, Claimant's doctor noted Claimant was noncompliant on all medications and misses meals. Claimant's doctor counseled Claimant regarding her nutrition and obesity and scheduled Claimant to see a dietician and to take diabetic classes. (Department Exhibit A, page 22).

(10) On August 1, 2010, Claimant was seen for outpatient counseling. Claimant was oriented to person, place and time. Her counselor noted Claimant exhibited anxiety, concrete thinking, depression, guilt, hopelessness, increased appetite/weight gain, insomnia, irritability, poor judgment, poor insight, rumination and had a sad and worrisome affect. She was prescribed Linospril, Simvasstatin, Metformin, Glipizide and a insulin/glargine injection once a day. It was noted Claimant has been smoking ½ a pack a day since age 13. Claimant was diagnosed with a GAF of 41 and a fair prognosis. (Department Exhibit A, page 30-32).

(11) On August 4, 2010, Claimant saw her doctor. He noted she was depressed and refused to eat a piece of candy to raise her sugar. (Department Exhibit A, page 21).

(12) On August 17, 2010, Claimant underwent a psychiatric evaluation. Claimant started drinking at the age of 16, drinking escalated until the age of twenty-five. She would drink up to 1 ½ fifths a day, three days a week. She slowed down her drinking between the ages of twenty-five and twenty-seven and these days she is drinking up to a fifth of liquor once a month. She started smoking marijuana at the age of 13, last use was at the age of 16. She ingests two caffeine pills a day, three energy drinks a

day, 20 cups of coffee a day and a 20 ounce pop a day. She smokes one pack of cigarettes and started smoking at the age of 13. Claimant had good eye contact, spoke spontaneously, fluently and coherently. She denied any intention to hurt herself. Her mood was depressed, her affect sad, but not tearful. She was alert and oriented with a considerable degree of anxiety regarding her son's health issues. Diagnosis: Axis I: Major depression recurrent, non-psychotic, alcohol dependence, nicotine dependence; Axis II: deferred; Axis III: hypertension, hyperlipidemia, diabetes mellitus; Axis IV: son's medical condition, being a single mother; Axis V: GAF 40. Claimant was encouraged to wean herself off of caffeine gradually, avoid alcohol and attend AA meetings. Claimant was prescribed Citralopram and Trazadone. (Department Exhibit A, pages 42-44).

(13) On September 2, 2010, Claimant's doctor noted Claimant was non-compliant with her psychiatric medications. Claimant was placed on new medications and he counseled her regarding her noncompliance, obesity, nutrition and smoking. (Department Exhibit A, page 20).

(14) On September 8, 2010, Claimant saw her counselor who noted Claimant's mood was more stable, affect was appropriate, and she was oriented to person, place and time. Claimant reported her sleep had increased and was sound. She had no anxiety attacks and her level of distress was reduced. She reported she was compliant with her Trazadone and Celexa medications. (Department Exhibit A, page 38).

(15) On September 14, 2010, Claimant met with her psychiatrist. Claimant stated she was very hyper because her brain is always running. She was treated with Ritalin from age 9 to age 16 and stopped using it due to lack of insurance. She is now using Adderall which she gets from friends and denies alcohol use. Claimant spoke spontaneously, fluently and coherently. Her thought processes were well organized and she was no longer depressed. She was alert and oriented and denied any feeling anxious or worried. Claimant was prescribed Citalopram, Trazadone, Guanfacine, and Strattera. (Department Exhibit A, page 41).

(16) On September 29, 2010, Claimant attended outpatient counseling. Claimant was prescribed Straterra which she had stopped taking because it upset her stomach. Claimant felt her current medications of Trazadone and Celexa were effective. (Department Exhibit A, page 37).

(17) On October 14, 2010, Claimant's doctor noted Claimant was noncompliant with her psychiatric recommendations. Clamant stated the Straltera made her sick and she was too sleepy on Trazadone. Claimant's prescriptions for Lantus, Glipizide and Metformin were renewed. (Department Exhibit A, page 19).

(18) On October 27, 2010, Claimant met with her counselor. Claimant was depressed, her affect was sad and angry. She denied suicidal ideation or intent and was oriented to person, place and time. She reported that her infant son had been diagnosed with cerebral palsy and may be diagnosed as autistic. She is irritable, easily upset and angry. She reported her sleep was disturbed. She had tried Adderall and felt it was effective. She reported she had not taken her medication in the past three weeks. GAF is 40. (Department Exhibit A, page 36).

(19) On October 29, 2010, Claimant was seen by her psychiatrist where Claimant denied alcohol and caffeine intake. She stated she smoked ½ pack a day and currently taking insulin, metformin, glipizide, lisinopril and simvastatin. Claimant stated she had quit taking Citalopram, Trazadone, Guanfacine, and Strattera. Claimant asked for a prescription for Adderall and admitted she was using Adderall she had received from friends. She had good eye contact, spoke spontaneously, fluently and coherently. Thought processes were well organized and goal directed. Her mood was no longer depressed and her affect was mobile. She was alert and oriented and did not show any restlessness or agitation. She denied feeling anxious or worried. Her psychiatrist discussed with her the need for compliance with her medication. (Department Exhibit A, page 40).

(20) On November 15, 2010, Claimant underwent a psychiatric evaluation. Claimant complained of being irritable and unable to concentrate. She feels Ritalin helped in the past. Her sleep and appetite were good and she exhibited no suicidal ideation or psychotic symptoms. Claimant had been in counseling since the summer of 2010, but "quit due to not getting medications she felt she needed." She felt she needed Ritalin. Currently, Claimant is on Metaformin and Glipizide. She is also taking insulin and blood pressure medication. Claimant is agitated, reports experiencing frustration and anger and has difficulty making decisions. Claimant has an 18-month old with health issues and Claimant stated she has been depressed since he was born. Claimant was friendly and cooperative, fully oriented to person, place and time, with no apparent memory problems. Her intellect is below average, her perception was normal and her thought process relevant. (Department Exhibit A, pages 65).

(21) On November 29, 2010, Claimant completed an Adult Self-Report (ASR) in order to obtain her perceptions of her adaptive functioning, substance abuse, and problems. On the adaptive functioning scales, Claimant's score on the Spouse/Partner scale was in the normal range. Her score on the Family scale was in the clinical range below the 3rd percentile. Her score on the Friends scale was in the borderline clinical range (3rd to 7th percentiles). Her Mean Adaptive score was in the clinical range below the 3rd percentile for self-reports by women aged 18 to 59. On the substance

use scales, her scores on the Tobacco, Alcohol and Drugs scales were in the normal range. Her Mean Substance Use score was in the normal range for self-reports by women aged 18 to 59. On the ASR problem scales, her Total Problems, Internalizing, Externalizing scores were all in the clinical range above the 90th percentile for women aged 18 to 59. Her scores on the Somatic Complaints and Intrusive syndromes were in the normal range. Her scores on the Anxious/Depressed, Withdrawn, Attention Problems, and Aggressive Behavior syndrome were in the clinical range above the 97th percentile. Her scores on the Through Problems and Rule-Breaking Behavior syndromes were in the borderline clinical range of 93rd to 97th percentiles. These results indicate she reported more problems than typically reported by women aged 18 to 59, particularly problems of anxiety or depression, withdrawn behavior, thought problems, attention problems, problems of an aggressive nature, and rule-breaking behavior. On the DSM-oriented scales, her score on the Somatic Problems scale was in the normal range. Her scores on the Avoidant Personality Problems, AD/H Problems, and Antisocial Personality Problems Scales were in the clinical range (above the 97th percentile). Her scores on the Depressive Problems and Anxiety Problems scales were in the borderline clinical range (93rd to 97th percentiles). These results suggest that the DSM should be consulted to determine whether she meets the diagnostic criteria for Avoidant Personality Disorder, Attention Deficit/Hyperactivity Disorder and Antisocial Personality Disorder. (Department Exhibit A, pages 56-58).

(22) On January 21, 2011, Claimant was prescribed Wellbutrin and Risperdol in addition to the Metformin and Lamoxil. Claimant told her doctor that she was smoking 1 pack a day. Claimant was diagnosed with obesity, tooth abscesses, IDDM, nicotine addition, depression, alcoholism, depression and ADHD. Her doctor counseled Claimant on nutrition, stopping smoking and obesity. (Department Exhibit A, page 18).

(23) On March 3, 2011, Claimant saw her doctor who noted Claimant was signing over her parental rights today, and she was upset but in general doing well. She was to continue with the same medications, Risperdal and Wellbutrin. (Department Exhibit A, page 70).

(24) On March 21, 2011, Claimant was seen by her doctor who noted her BMI was 4.06 and counseled her on obesity and smoking. He diagnosed Claimant with IDDM, hypercholesterol, hypertension, obesity, nicotine addition and acute adjustment disorder. (Department Exhibit A, page 17).

(25) On April 13, 2011, Claimant completed the Activities of Daily Living form explaining she needed reminders for grooming, bathing, etc., and medication schedule and meals. Claimant wrote she has more difficulty

remembering to eat or to see connections between her diabetes and food intake. (Department Exhibit A, page 11-15).

(26) On May 24, 2011, Claimant underwent a psychological mental status examination and stated she had social anxiety, ADHD and Avoidant Personality Disorder. Claimant indicated that she had never been psychiatrically hospitalized, by had attended outpatient counseling, although she was not currently attending. Claimant was not currently taking any medications, although she had been prescribed Xanax, Wellbutrin, Risperdal, Glipizide, Meformin, Insulin and cholesterol medications. Claimant stated she was out of insulin and her blood sugars had been running about 555. Claimant explained that she is insulin dependent and has not been taking her medications because they cost too much. Claimant was alert and well oriented during the interview. She was polite and cooperative, and spontaneous, well organized and detailed in her presentation. Her memory was in the mildly impaired range and her fund of general information was very constricted. She was poor at mental arithmetic. Her formal judgment was marginal and her operational judgment was highly questionable given her going without her insulin and the issue of having her son removed from her car by DHS. It appears that Claimant has significant problems carrying out day to day functional responsibilities. Diagnosis: Axis I: Depressive Disorder NOS; Axis II: Mild Cognitive Impairment; Axis III: Insulin Dependent Diabetes, Mellitus by history; Axis IV: Problems in employment, primary support and with physical health; Axis V: Current GAF 45 (serious impairment in social and occupational functioning). Prognosis is guarded. She is unable to manage her own funds. (Department Exhibit A, pages 3-5).

(27) Claimant is a [redacted] woman whose birthday is [redacted] Claimant is 5'4" tall and weighs 200 lbs. Claimant completed high school taking special education classes and last worked in 2007 as a newspaper carrier and prior to that as a dishwasher.

(28) Claimant was denied Social Security disability benefits and is appealing that determination.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> . . . the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905.

A set order is used to determine disability, that being a five-step sequential evaluation process for determining whether an individual is disabled. (20 CFR 404.1520(a) and 416.920(a)). The steps are followed in order. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the Administrative Law Judge must determine whether the claimant is engaging in substantial gainful activity. (20 CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. "Substantial work activity" is work activity that involves doing significant physical or mental activities. (20 CFR 404.1572(a) and 416.972(a)). "Gainful work activity" is work that is usually done for pay or profit, whether or not a profit is realized. (20 CFR 404.1572(b) and 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in SGA. (20 CFR 404.1574, 404.1575, 416.974, and 416.975). If an individual engages in SGA, he/she is not disabled regardless of how severe his/her physical or mental impairments are and regardless of his/her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the Administrative Law Judge must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe." (20 CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work. (20 CFR 404.1521 and 416.921; Social Security Rulings (SSRs) 85-28, 96-3p, and 96-4p). If the claimant does not have a severe medically determinable impairment or combination of impairments, he/she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment. 20 CFR 416.929(a).

Medical reports should include –

(1) Medical history.

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include –

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c). A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

At step three, the Administrative Law Judge must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1. (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement, (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the Administrative Law Judge must first determine the claimant's residual functional capacity. (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is his/her ability to do physical and mental work activities on a sustained basis despite limitations from his/her impairments. In making this finding, all of the claimant's impairments, including impairments that are not severe, must be considered. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p).

Next, the Administrative Law Judge must determine at step four whether the claimant has the residual functional capacity to perform the requirements of his/her past relevant work. (20 CFR 404.1520(f) and 416.920(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA. (20 CFR 404.1560(b), 404.1565, 416.960(b), and 416.965). If the claimant has the residual functional capacity to do his/her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g) and 416.920(g)), the Administrative Law Judge must determine whether the claimant is able to do any other work considering his/her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, he/she is not disabled. If the claimant is not able to do other work and meets the duration requirements, he/she is disabled.

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

At Step 1, Claimant is not engaged in substantial gainful activity and testified that she has not worked since 2007. Therefore, Claimant is not disqualified from receiving disability at Step 1.

At Step 2, in considering Claimant's symptoms, whether there is an underlying medically determinable physical or mental impairment(s)-i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques-that could reasonably be expected to produce Claimant's pain or other symptoms must be determined. Once an underlying physical or mental impairment(s) has been shown, the Administrative Law Judge must evaluate the intensity, persistence, and limiting effects of Claimant's symptoms to determine the extent to which they limit Claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, a finding on the credibility of the statements based on a consideration of the entire case record must be made.

At Step 2, the objective medical evidence of record shows Claimant was diagnosed with insulin dependent diabetes, ADHD, depression, anxiety, avoidant personality disorder, hypertension, dyslipidemia and a history of caffeine, alcohol and tobacco dependence. The finding of a severe impairment at Step 2 is a *de minimus* standard. This Administrative Law Judge finds that Claimant established that at all times relevant to this matter Claimant had insulin dependent diabetes, ADHD, depression, anxiety, avoidant personality disorder, hypertension, dyslipidemia and a history of caffeine, alcohol and tobacco dependence which would affect her ability to do substantial gainful activity. Therefore, the analysis will continue to Step 3.

At Step 3 the trier of fact must determine if the Claimant's impairment (or combination of impairments) is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. This Administrative Law Judge finds that Claimant's medical record will not support a finding that Claimant's impairment(s) is a "listed impairment" or equal to a listed impairment. Accordingly, Claimant cannot be found to be disabled based upon medical evidence alone. 20 CFR 416.920(d).

At Step 4, Claimant's past relevant employment has been as a banquet server and a cabinet maker. The objective medical evidence of record is not sufficient to establish that Claimant has severe impairments that have lasted or are expected to last 12 months or more and prevent him from performing the duties required from her past relevant employment for 12 months or more. Accordingly, Claimant is disqualified from receiving disability at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not Claimant has the residual functional capacity to perform other jobs.

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor. 20 CFR 416.967.

Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b).

Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work. 20 CFR 416.967(c).

Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. 20 CFR 416.967(d).

At Step 5, the burden of proof shifts to the department to establish that Claimant does have residual functional capacity. The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. See discussion at Step 2 above. Findings of Fact 14-16, 19-21, 26-27.

At Step 5, the objective medical evidence of record is sufficient to establish that Claimant is capable of performing at least light duties. Claimant alleges she suffers from a history of ADHD, depression, anxiety, avoidant personality disorder, hypertension, insulin dependent diabetes, dyslipidemia and alcohol, nicotine and caffeine dependence.

In May 2010, Claimant's doctor noted she was noncompliant with her diet and her alcohol intake had increased. In June 2010, August 2010, and October 2010, Claimant's doctor found Claimant was noncompliant with her medications and was missing meals. Claimant's doctor counseled Claimant at every visit on her obesity, nutrition, smoking, and her noncompliance with her psychiatric medications.

During the first week of September 2010, Claimant met with her psychiatrist who noted her mood was more stable. She reported her sleep had increased and was sound. She had no anxiety attacks and her level of distress was reduced. She reported she was compliant with her Trazadone and Celexa medications. Claimant met with her counselor twice in September 2010. He noted Claimant's thought processes were well organized and she was no longer depressed. She was alert and oriented and denied feeling anxious or worried. She felt her current medications of Trazadone and Celexa were effective.

Beginning October 14, 2010, Claimant's doctor noted Claimant was noncompliant with her psychiatric medications. On October 27, 2010, Claimant met with her counselor and was depressed. Her affect was sad and angry. She was irritable, easily upset and angry. She reported her sleep was disturbed. She admitted she had not taken her psychiatric medications in three weeks, but was using Aderall, which she stated she had obtained from friends and she felt it was effective. On October 29, 2010, Claimant told her psychiatrist that she had quit taking her prescribed medications and asked for a prescription for Adderall, which she had received from friends and was using. Her psychiatrist noted that her thought processes were well organized and goal directed. Her mood was no longer depressed. She was alert and did not exhibit any restlessness or agitation. She denied feeling anxious or worried.

On November 15, 2010, during a psychiatric evaluation, Claimant complained of being irritable and unable to concentrate. She stated Ritalin had helped in the past. Claimant admitted she had been in counseling since the summer of 2010 and she had quit because she was not getting the medication that she felt she needed. She felt she needed Ritalin. Claimant was agitated and reported experiencing frustration and anger and had difficulty making decisions.

On November 29, 2010, Claimant completed an Adult Self-Report (ASR) which showed her Adaptive Functioning scale, Spouse/Partner scale, Tobacco/Alcohol and Drugs scale, Somatic Complaints and Intrusive Syndrome scale and DSM-oriented scales were all in the normal range. On January 21, 2011, Claimant stated she was smoking a pack a day. Claimant's doctor counseled her on nutrition, the benefits of stopping smoking and obesity.

In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work. CFR 416.930(a). If you do not follow the prescribed treatment without a good reason, you will not be found disabled. CFR 416.930(b). Claimant admittedly has been noncompliant in following her doctor's, counselor's and psychiatrist's treatment recommendations.

Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does establish that Claimant has the residual functional capacity to perform other work. As a result, Claimant is disqualified from receiving disability at Step 5 based upon the fact that the objective medical evidence on the record shows she can perform sedentary work. Under the Medical-Vocational guidelines, a younger individual age 18-49 (Claimant is 32 years of age), with limited education (Claimant completed high school), and an unskilled or limited work history, is not considered disabled pursuant to Medical-Vocational Rule 201.27.

As a result, Claimant has not presented the required competent, material, and substantial evidence which would support a finding that Claimant has an impairment or combination of impairments which would significantly limit the physical or mental ability to do basic work activities. 20 CFR 416.920(c). Although Claimant has cited medical problems, the clinical documentation submitted by Claimant is not sufficient to establish a finding that Claimant is disabled. There is no objective medical evidence to substantiate Claimant's claim that the alleged impairment(s) are severe enough to reach the criteria and definition of disabled. Accordingly, Claimant is not disabled for the purposes of the Medical Assistance disability (MA-P) program.

The department's Bridges Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. BEM, Item 261, p 1. Because Claimant does not meet the definition of disabled under the MA-P program and because the evidence of record does not establish that Claimant is unable to work for a period exceeding 90 days, Claimant does not meet the disability criteria for State Disability Assistance benefits either.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that Claimant was not eligible to receive Medical Assistance and/or State Disability Assistance.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has appropriately established on the record that it was acting in compliance with department policy when it denied Claimant's application for Medical Assistance, retroactive Medical Assistance and State Disability Assistance benefits.

Accordingly, the department's decision is AFFIRMED.

It is SO ORDERED.

/s/
Vicki L. Armstrong
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: 11/14/11

Date Mailed: 11/14/11

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

VLA/ds