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

IN THE MATTER OF:

[redacted]

Reg. No: 2011-38180
Issue No: 2009/4031
Case No: [redacted]
Hearing Date:
September 15, 2011
Clare 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 September 15, 2011. Claimant personally appeared and testified.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional medical evidence. The new evidence was forwarded to the State Hearing Review Team ("SHRT") for consideration. On January 4, 2012, the SHRT found Claimant was not disabled. This matter is now before the undersigned for a final decision.

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 November 5, 2010, Claimant filed an application for MA, Retro-MA, and SDA benefits alleging disability.

(2) On May 31, 2011, the Medical Review Team (MRT) denied Claimant's application for MA-P and Retro-MA indicating that she was capable of performing other work, pursuant to 20 CFR 416.920(f). SDA was denied for lack of duration.

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

(4) On June 9, 2011, Claimant filed a request for a hearing to contest the department's negative action.

(6) On July 17, 2011, and January 4, 2012, the State Hearing Review Team (SHRT) found Claimant was not disabled. (Department Exhibit B, pp 1-2; Department Exhibit C, pp 1-2).

(7) Claimant has a history of severe depression, chronic obstructive pulmonary disease (COPD), arthritis, diverticulosis, chronic fatigue syndrome, fibromyalgia, and anxiety.

(8) On October 28, 2009, Claimant saw her psychiatrist at Community Mental Health (CMH). Her last visit had been 8/19/09. She was doing fairly well overall. She has had some ups and downs. She has continued on Vicodin and Ambien. She sleeps fairly well at nighttime. Her mood has generally been good. Overall she feels she is managing reasonably well. She has a better outlook. She acknowledges that she does tend to use some other prescription drugs from time to time. She may borrow her boyfriend's Ativan. She also acknowledges that perhaps a couple of times a month, she may get some opioid pain medications and use them on a single occasion. She notes that she had some periods in the past where she was free of all habit forming chemicals and acknowledges that she did feel better, though it had been a long time. She notes that she has gone on and off Zyprexa. She had one episode where she went off of both Zyprexa and Synthroid. She stated that each time she has gone off Zyprexa, within a few days she has a lot of physical and mental symptoms. When she goes back on Zyprexa, those symptoms are relieved. She tolerates her medications well. At her appointment, she sat without restlessness. She had good eye contact. She answered questions appropriately. Her thoughts were clear. She was fairly interactive. It was noteworthy that she seemed just a little more relaxed and a little bit more connected to the conversation. Insights were somewhat more acute than has been the case in the past. She was willing to consider alternatives when various treatment options were discussed. Claimant was continued on Zyprexa and Celexa. (Department Exhibit A, pp 72-73).

(9) On December 29, 2009, Claimant saw her doctor believing she had irritable bowel syndrome and that she needed to have her thyroid checked because she was tired easily. She had a colonoscopy two months ago, and was not due for another for 10 years. She had some thyroid tests in October 2009 which were normal. The doctor explained that fatigue is not just from her thyroid, but could be due to a combination of allergies and

anxiety. The doctor found that while she might have irritable bowel syndrome, the doctor wanted her to try fiber for awhile and drink lots of fluids. Her Epstein-Barr virus was positive which also contributed to her feeling of fatigue and tiredness. (Department Exhibit A, pp 82, 107-108).

(10) On February 1, 2010, Claimant saw her doctor complaining of feeling tired all the time and losing her appetite. She had shortness of breath and was aching all over. The doctor opined that the body weakness and energy was a part of depression and she may also have fibromyalgia since she stated she ached all over. She had a history of back pain and neck pain due to arthritis. Her blood tests were reviewed and they were normal. Her COPD was noted to be mild. The doctor explained that just because she has COPD does not mean she has a heart problem and there was no need to see a cardiologist at this time. She had a cardiac workup 2 years ago and from a cardiac standpoint she had no problem in that area. She was referred for an evaluation of possible myalgia. (Department Exhibit A, pp 110-111).

(11) On March 17, 2010, Claimant was seen for generalized body aches, complaining of soreness in both shoulders. Claimant was prescribed Vicodin. (Department Exhibit A, p 112).

(12) On April 15, 2010, Claimant saw her doctor for generalized body aches, due to fibromyalgia. Claimant was given refills for Tramadol. (Department Exhibit A, p 113).

(13) On May 10, 2010, Claimant saw her doctor for low back pain. She was having pain in both flank areas with back spasms and bilateral swelling. (Department Exhibit A, p 114).

(14) On May 30, 2010, Claimant went to the emergency department with her left wrist in an ace wrap. She reported edema on the outer side of her left wrist which started last week with a lump on the wrist and now involves the entire wrist. She stated she cannot use it for activities of daily living. The pain is from the middle of her forearm to her fingertips. An x-ray of Claimant's left wrist showed a 9mm cortication distal to the ulnar styloid likely representing an unfused apophysis. There was no evidence of acute fracture/dislocation. She was prescribed Vicodin and a short splint was applied. She was discharged and instructed to wear the splint except when bathing, and apply heat and ice as directed and told to return to the emergency department if the pain worsened. (Department Exhibit A, pp 78, 83-91, 102).

(15) On June 2, 2010, Claimant reported to the emergency department for left arm pain, uncontrolled by the Vicodin. She stated the Vicodin kept her awake so she did not take it after eight at night. She was cooperative, but

anxious and crying. Her elbow was swollen. She had decreased range of motion and weakness. She was diagnosed with a left wrist sprain. She was administered Percocet, Toradol and Valium and discharged. (Department Exhibit A, pp 92-97).

(16) On July 8, 2010, Claimant saw her doctor for multiple joint pain, worse in her back and in the morning. She had a history of fibromyalgia and anxiety. Her lumbar spine was tender and she had swelling and tenderness in both wrists. She was diagnosed with low back pain. (Department Exhibit A, p 115).

(17) On August 2, 2010, Claimant saw her doctor complaining of stomach trouble. She was diagnosed with diverticulosis, positive for chronic fatigue syndrome, fibromyalgia, COPD, depression and anxiety. Her doctor prescribed a certain diet to follow to prevent the frequent flare-ups of diverticulosis. (Department Exhibit A, pp 117-118).

(18) On April 23, 2011, Claimant underwent a medical examination on behalf of the department. A chest examination found a prolongation of the expiratory phase. There were mild bronchial breath sounds. There was a mild degree of impairment. A musculoskeletal examination revealed no evidence of joint laxity, crepitance, or effusion. Grip strength remained intact. Dexterity was unimpaired. She could open a door and had no difficulty getting on and off the examination table, no difficulty heel and toe walking, no difficulty squatting, and no difficulty standing on either foot. Straight leg raise was negative. There were no paravertebral muscle spasms. The neurological examination showed her cranial nerves were intact. Motor strength and tone were normal. Sensory was intact to light touch and pinprick. Reflexes were 2+ and symmetrical. Romberg testing was negative. She walked with a normal gait without the use of an assistive device. The doctor noted Claimant last used her bronchodilator the night before and that she experienced shortness of breath and chest pain during the pulmonary function test. Based on the examination, the doctor concluded Claimant had emphysema and arthralgias. There were no orthopedic deficits and her range of motion was normal. Much of her complaints appeared to be related to her sedentary lifestyle, lack of activity and depression. Her overall degree of impairment appeared to be mild, and her prognosis was fair and stable. (Department Exhibit A, pp 137-142).

(19) On May 9, 2011, Claimant underwent a psychological examination for the State of Michigan. The psychologist noted her emotional reaction was depressed. The psychologist opined that she was able to understand, retain and follow simple instructions. She could be expected to understand simple changes in the work environment. She reported a significant history of depression that has had a negative impact on her

functioning. The problems appear to interact to limit the type of employment settings where she could be expected to excel. Her presentation was consistent with a diagnosis of major depression and a panic disorder. Her prognosis was guarded because she lacked concrete vocations skills that allow her to adapt to her worsening health conditions. GAF=65. (Department Exhibit A, pp 144 -147).

(20) On September 21, 2011, Claimant presented to Community Mental Health for an evaluation and was diagnosed with Panic Disorder without agoraphobia, and Major Depressive Disorder. GAF=50. (Department Exhibit A, pp 151-160).

(21) Claimant is a 50 year old woman whose birthday is [redacted]. Claimant is 5'7" tall and weighs 128 lbs. Claimant completed high school.

(22) Claimant was appealing the denial of Social Security disability benefits at the time of the hearing.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department, (DHS or department), 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").

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. The Department of Human Services (DHS or department) administers the SDA program pursuant to MCL 400.10, *et seq.*, and Mich Admin Code, Rules 400.3151-400.3180. Department policies are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

Current legislative amendments to the Act delineate eligibility criteria as implemented by department policy set forth in program manuals. 2004 PA 344, Sec. 604, establishes the State Disability Assistance program. It reads in part:

> Sec. 604 (1). The department shall operate a state disability assistance program. Except as provided in subsection (3), persons eligible for this program shall include needy citizens of the United States or aliens exempt from the Supplemental Security Income citizenship requirement who are at least 18 years of age or emancipated minors meeting one or more of the following requirements:

> (b) A person with a physical or mental impairment which meets federal SSI disability standards, except that the minimum duration of the disability shall be 90 days. Substance abuse alone is not defined as a basis for eligibility.

Specifically, this Act provides minimal cash assistance to individuals with some type of severe, temporary disability which prevents him or her from engaging in substantial gainful work activity for at least ninety (90) days.

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). The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.927.

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and, (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (e.g., age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a

particular step, the next step is required. 20 CFR 416.920(a)(4). If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from Step 3 to Step 4. 20 CFR 416.920(a)(4); 20 CFR 416.945. Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1). An individual's residual functional capacity assessment is evaluated at both Steps 4 and 5. 20 CFR 416.920(a)(4). In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv). In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a). An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a). The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6).

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity and testified that she has not worked since April 2008. Therefore, she is not disqualified from receiving disability benefits under Step 1.

The severity of the individual's alleged impairment(s) is considered under Step 2. The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b). An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(c). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b). Examples 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. *Id.*

The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985).

In the present case, Claimant alleges disability due to severe depression, chronic obstructive pulmonary disease (COPD), arthritis, diverticulosis, chronic fatigue syndrome, fibromyalgia, and anxiety.

On October 28, 2009, Claimant saw her psychiatrist at Community Mental Health (CMH). Overall she felt she is managing reasonably well. She has a better outlook. She sat without restlessness. She had good eye contact. She answered questions appropriately. Her thoughts were clear. She was fairly interactive. It was noteworthy that she seemed just a little more relaxed and a little bit more connected to the conversation. Insights were somewhat more acute than had been the case in the past. She was willing to consider alternatives when various treatment options were discussed.

On December 29, 2009, Claimant saw her doctor complaining of fatigue. The doctor explained that the combination of allergies, anxiety and her positive Epstein-Barr virus test could contribute to her feeling of fatigue and tiredness.

On February 1, 2010, Claimant saw her doctor complaining of feeling tired all the time and losing her appetite. She had shortness of breath and was aching all over. The doctor opined that the body weakness and energy was a part of depression and she may also have fibromyalgia since she stated she ached all over. Her blood tests were reviewed and they were normal. Her COPD was noted to be mild.

On May 30, 2010, Claimant went to the emergency department with her left wrist in an ace wrap. An x-ray of Claimant's left wrist showed a 9mm cortication distal to the ulnar styloid likely representing an unfused apophysis. There was no evidence of acute fracture/dislocation. She was prescribed Vicodin and a short splint was applied.

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On May 9, 2011, Claimant underwent a psychological examination for the State of Michigan. The psychologist opined that she was able to understand, retain and follow simple instructions. She could be expected to understand simple changes in the work environment. She reported a significant history of depression that has had a negative impact on her functioning. The problems appeared to interact to limit the type of employment settings where she could be expected to excel. Her presentation was consistent with a diagnosis of major depression and a panic disorder. Her prognosis was guarded because she lacked concrete vocations skills that allow her to adapt to her worsening health conditions. GAF=65.

On September 21, 2011, Claimant presented to Community Mental Health for an evaluation and was diagnosed with Panic Disorder without agoraphobia, and Major Depressive Disorder. GAF=50.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, Claimant has presented some limited medical evidence establishing that she does have some physical limitations on her ability to perform basic work activities. The medical evidence has established that Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. Claimant has alleged physically and mentally disabling impairments due to severe depression, chronic obstructive pulmonary disease (COPD), arthritis, diverticulosis, chronic fatigue syndrome, fibromyalgia, and anxiety.

Listing 1.00 (musculoskeletal system), Listing 3.00 (respiratory system), Listing 11.00 (neurological), Listing 12.00 (mental disorders) and Listing 14.00 (immune system disorders) were considered in light of the objective evidence. Based on the foregoing, it is found that Claimant's impairment(s) does not meet the intent and severity requirement of a listed impairment; therefore, Claimant cannot be found disabled at Step 3. Accordingly, Claimant's eligibility is considered under Step 4. 20 CFR 416.905(a).

The fourth step in analyzing a disability claim requires an assessment of the individual's residual functional capacity ("RFC") and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if he/she can perform past relevant work. *Id*.; 20 CFR 416.960(b)(3). Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s) and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

To determine the physical demands (exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). 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. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands (exertional requirements, e.g., sitting, standing, walking, lifting, carrying, pushing, or pulling) are considered nonexertional. 20 CFR 416.969a(a). In considering whether an individual can perform past relevant work, a comparison of the individual's residual functional capacity to the demands of past relevant work must be made. *Id.* If an individual can no longer do past relevant work, the same residual functional capacity assessment along with an individual's age, education, and work experience is considered to determine whether an individual can adjust to other work which exists in the national economy. *Id.* Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2). The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

Claimant's prior work history consists of work doing pizza delivery, providing home health care and working in the floral department of a grocery store. In light of Claimant's testimony, and in consideration of the Occupational Code, Claimant's prior work is classified as unskilled, light work.

Claimant testified that she is able to walk "a couple of blocks," stand and sit for two hours and can lift/carry approximately 5 pounds. The objective medical evidence notes no physical limitations. If the impairment or combination of impairments does not limit an individual's physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of the Claimant's testimony, medical records, and current limitations, Claimant can be found able to return to past relevant work. However, Step 5 of the sequential analysis will still be completed.

In Step 5, an assessment of the individual's residual functional capacity and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v) At the time of hearing, the Claimant was 50 years old and was, thus, considered to be approaching advanced age for MA-P purposes. Claimant has a high school degree. Disability is found if an individual is unable to adjust to other work. *Id.* At this point in the analysis, the burden shifts from the Claimant to the Department to present proof that the Claimant has the residual capacity to substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the

vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). The age for younger individuals (under 50) generally will not seriously affect the ability to adjust to other work. 20 CFR 416.963(c).

In this case, the evidence reveals that Claimant suffers severe depression, chronic obstructive pulmonary disease (COPD), arthritis, diverticulosis, chronic fatigue syndrome, fibromyalgia, and anxiety. The objective medical evidence notes no limitations. In light of the foregoing, it is found that the Claimant maintains the residual functional capacity for work activities on a regular and continuing basis which includes the ability to meet the physical and mental demands required to perform at least light work as defined in 20 CFR 416.967(b). After review of the entire record using the Medical-Vocational Guidelines [20 CFR 404, Subpart P, Appendix II] as a guide, specifically Rule 202.13**,** it is found that the Claimant is not disabled for purposes of the MA-P and SDA programs at Step 5.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Claimant not disabled for purposes of the MA-P and SDA benefit programs.

Accordingly, it is ORDERED:

The Department's determination is AFFIRMED.

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

Date Signed: 1/26/12

Date Mailed: 1/26/12

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