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

**IN THE MATTER OF:**

[redacted]

Reg. No.: 20148238
Issue No.: 2009; 4009
Case No.: [redacted]
Hearing Date: March 5, 2014
County: Wayne (41)

**ADMINISTRATIVE LAW JUDGE:** Alice C. Elkin

## HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 5, 2014 from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Human Services (Department) included [redacted], Hearing Coordinator/PATH Specialist, and [redacted], Medical Contact Worker/Eligibility Specialist.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. An interim order extending the record was issued on March 7, 2014 ordering the Department to provide additional medical records from Claimant's psychiatrist, including a mental residual functional capacity assessment. None of the ordered records were received, and the Department failed to respond to repeated requests for information concerning those records. In light of the lapse of the period for the record extension and the Department's failure to provide requested documents, the record was closed and this matter is now before the undersigned for a final determination.

## ISSUE

Did the Department properly determine that Claimant was not disabled for purposes of the Medical Assistance (MA-P) and State Disability Assistance (SDA) benefit programs?

## FINDINGS OF FACT

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

1. On June 7, 2013, Claimant submitted an application for public assistance seeking MA-P, with a request for retroactive coverage to March 2013, and SDA benefits.

2. On August 8, 2013, the Medical Review Team (MRT) found Claimant not disabled.

3. On August 15, 2013, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.

4. On October 22, 2013, the Department received Claimant's timely written request for hearing.

5. On January 15, 2014, the State Hearing Review Team (SHRT) found Claimant not disabled.

6. Claimant alleged mental disabling impairments secondary to a traumatic brain injury, depression, and hallucinations.

7. At the time of hearing, [redacted], birth date; he was [redacted].

8. Claimant has a GED degree and a truck driver license (CDL) and an auto mechanic certificate.

9. Claimant has an employment history of work as a truck driver, housekeeper and fast food employee.

10. Claimant's impairments have lasted, or are expected to last, continuously for a period of 12 months or longer.

## CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105.

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program purusant to MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Department policies are found in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Bridges Reference Tables (RFT).

MA-P and SDA benefits are available to disabled individuals. BEM 105 (January 2014), p. 1; BEM 260 (July 260); BEM 261 (July 2013), p. 1. In order to receive MA benefits based upon disability, Claimant must be disabled as defined in Title XVI of the Social Security Act. 20 CFR 416.901. Disability for MA purposes 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).

In order to determine whether or not an individual is disabled, federal regulations require application of a five-step sequential evaluation process. 20 CFR 416.920(a)(1). The five-step analysis requires the trier of fact to consider (1) whether the individual is engaged in substantial gainful activity (SGA); (2) whether the individual's impairment is severe; (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) whether the individual has the residual functional capacity to perform past relevant work; and (5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to 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 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)

In general, the individual has the responsibility to establish a disability 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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, are insufficient to establish disability. 20 CFR 416.927(d).

**Step One**

As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is substantial gainful activity (SGA), then the individual must be considered as not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under step 1 and the analysis continues to step 2.

**Step Two**

Under step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 20 CFR 416.922.

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 416.920(a)(4)(ii); 20 CFR 416.920(c). 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); see also *Salmi v Sec of Health and Human Services,* 774 F2d 685, 692 (CA 6, 1985). Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. A disability claim obviously lacking in medical merit may be dismissed. *Higgs v Bowen,* 880 F2d 860, 862 (CA 6, 1988). The severity requirement may 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).

However, under the *de minimus* standard applied at step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs* at 862.

As previously noted, Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). In the present case, Claimant alleges disability due to depression, memory loss, and hallucinations. The medical record also presents documentation of headaches and body aches.

Claimant was in a severe motor vehicle accident in 2007. According to the statements Claimant made to doctors during medical exams, as reflected in the doctors' reports, the accident resulted in a traumatic brain injury, and Claimant was on life support for three days, in a medically-induced coma for two days, and hospitalized for three months. The hospitalization was followed by several months of physical, occupational and speech therapy.

In an August 15, 2012 initial psychiatric evaluation, Claimant told the doctor that he had been on life support and had to undergo rehabilitative therapy following the 2007 accident. Since the accident, he has been depressed and feels anxious. He reported that he heard voices but could not make out what they said. He had also reported visual hallucinations of ghosts and spirits. He had passive suicidal thoughts in the past but denied any homicidal thoughts. Claimant told the doctor that he used to drink heavily but stopped after his accident and, for the last few years prior to the date of the evaluation, drank only on the weekends. In the mental status examination, the doctor noted that Claimant was neatly and appropriately dressed; cooperative; oriented to time, place and person; and making fairly good eye contact. He had a blunted affect and his speech was monotonous but normal in volume and tone and logical.

The doctor diagnosed Claimant with major depressive disorder, recurrent severe with psychotic features; posttraumatic stress disorder; and alcohol dependence in partial remission. Claimant's global assessment of functioning (GAF) score on the date of the exam was 50. He was prescribed Cymbalta for depression and Seroquel for psychosis and depression.

A January 7, 2013 physical exam report was prepared by a consulting physician at the request of the Social Security Administration for evaluation of traumatic brain injury, memory loss, headaches and body aches. Claimant reported that after he suffered a traumatic brain injury in the 2007 car accident, he began having headaches, which are associated with occasional episodes of nausea, vomiting, bilateral blurry vision and photophobia; body aches; and long- and short-term memory issues. The doctor found no limitation in range of motion for any checked joints; no tenderness, erythema, or effusion of any joint; symmetrical straight leg raising; no edema or varicose veins; normal grip strength; full hand dexterity; no difficulty in getting on and off the

examination table, heel and toe walking, and hopping; and mild difficulty in squatting. Motor strength was identified as 5/5, with intact sensation and present and symmetrical reflexes. The doctor concluded that Claimant was neurologically intact and demonstrated no difficulty with ambulation, noting that he did not use an assistive device to ambulate and had no limp. He also noted that Claimant denied taking any pain medication for symptom relief relating to his headaches and he had no tenderness to palpation of his head and was neurologically intact.

The June 6, 2013 treatment notes completed by LSBM in a follow-up to the 2012 psychiatric evaluation revealed that Claimant's hygiene and grooming were good, that he was alert and oriented, and he expressed interest in engaging in treatment. Claimant reported that his family supported him by giving him rides to appointments but he had no friends because the people he knew where involved in alcohol and he did not engage in such activities.

An August 22, 2013 mental status exam report was prepared by a consulting physician at the request of the Social Security Administration. Claimant reported to the doctor that was employed full-time as a truck driver until his 2007 car accident and that following the accident he suffered a traumatic brain injury and was on life support for three days and then in an induced coma for two days. He was hospitalized for three months and then had outpatient rehabilitative physical, speech and occupational therapy for several months but he was unable to return to work as a truck driver. He supported himself through public food assistance benefits and resided in a home that was paid for. Since the accident, he complained of anxiety, memory problems, and body aches. He also reported visual hallucinations and scary dreams. He was prescribed Cymbalta and Seroquel for his psychiatric symptoms but admitted that he did not like them and sometimes threw them out.

The doctor noted that there were several inconsistencies in Claimant's description of his history, as well as his response styles and ability to comprehend and provide correct answers. The doctor explained that Claimant had initially provided a generally logical and sequential history and description of his work activities as well as his hospitalization and medical treatment but then had significant problems with simple questions during the mental status exam. The doctor noted that Claimant's affect was dull; his mood was a little distracted and preoccupied but there was no evidence of depression.

The doctor diagnosed Claimant with mood disorder secondary to closed head injury and chronic alcohol dependence, and personality disorder, noting that he was noncompliant with psychiatric medication. The doctor noted that Claimant's description of his activities of daily living suggested that he was generally independent with self-care and getting along with his girlfriend. The doctor concluded that there was "a suggestion that Claimant was malingering and exaggerating cognitive impairments possibly for secondary gain and there was insufficient medical evidence or supporting history to

make a definitive diagnosis or determine his ability to do work-related activities." Claimant was given a GAF score of 51 and a prognosis of guarded.

As summarized above, Claimant has presented medical evidence establishing that he does have some mental and physical limitations on his ability to perform basic work activities. In consideration of the *de minimis* standard necessary to establish a severe impairment under step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 12 months. Therefore, Claimant has satisfied the requirements under step 2, and the analysis will proceed to step 3.

**Step Three**

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Claimant's record reflects mental disorders. Based on the record presented, several listings in 12.00 concerning mental disorders, specifically Listings 12.02 (organic mental disorders), 12.03 (schizophrenic, paranoid and other psychotic disorders), 12.04 (affective disorder), 12.08 (personality disorder), 12.09 (substance addiction disorder), and 12.10 (autistic disorder and other pervasive developmental disorders), were considered.

The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. Listing 12.00A. The existence of a medically determinable impairment(s) of the required duration must be established through medical evidence consisting of symptoms, signs, and laboratory findings, to include psychological test findings. 12.00B. The evaluation of disability on the basis of a mental disorder requires sufficient evidence to (1) establish the presence of a medically determinable mental impairment(s), (2) assess the degree of functional limitation the impairment(s) imposes, and (3) project the probable duration of the impairment(s). 12.00D.

In this case, the record confirms the diagnoses of major depressive disorder, recurrent, severe with psychotic features; mood disorder; personality disorder; and alcohol dependence. Claimant had a GAF no greater than 51 and a guarded prognosis. The record presented showed no evidence of any marked restriction in any of the four functional areas or any repeated episodes of decompensation necessary to support any

of the considered listings in 12.00. The evidence presented is not sufficient to establish the degree of severity to meet any of the listings considered or the medically equivalent of any listing. Accordingly, Claimant cannot be found disabled, or not disabled, at step 3 based on his mental condition.

The record also shows that Claimant alleged a disability based on headaches and body aches, but the medical evidence presented does not support a finding that any of these conditions meet, or equal, the severity of a Listing under 11.00 (neurological) or 1.00 (musculoskeletal).

Because Claimant's physical and mental conditions are insufficient to meet, or to equal, the severity of a listing, Claimant is not disabled under step 3 and the analysis continues to step 4.

**Residual Functional Capacity**

If an individual's impairment does not meet or equal a listed impairment under step 3, before proceeding to step 4, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4). The total limiting effects of all impairments, including those that are not severe, are considered. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants 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).

Limitations can be exertional, non-exertional, or a combination of both. 20 CFR 416.969a. If the limitations and restrictions imposed by the individual's impairment(s) and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only non-exertional limitations or restrictions. 20 CFR 416.969a(a) and (c). 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 (i.e., 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).

For mental conditions, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). Four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

When a person has a combination of exertional and non-exertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination unless there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, the record shows that Claimant alleged both exertional and non-exertional limitations. The record shows that, while Claimant alleged body aches, the January 7, 2013, physical exam report showed that Claimant did not use, or claim need for, any assistive device to ambulate. The doctor found no limitation in range of motion for any checked joints; no tenderness, erythema, or effusion of any joint; symmetrical straight leg raising; no edema or varicose veins; normal grip strength; full hand dexterity; no difficulty in getting on and off the examination table, heel and toe walking, and hopping; and mild difficulty in squatting. Motor strength was identified as 5/5, with intact sensation and present and symmetrical reflexes.

At the hearing, Claimant testified that he had difficulty walking and standing because he sometimes fell without explanation. He tried to limit his lifting because he sometimes fell down. He also testified that he had aches and pains in his legs, back and arms that went away with stretching. He testified that he lived alone and was able to take care of his personal hygiene and dress himself.

The evidence presented does not establish any significant limitations on Claimant's ability to meet any exertional work demands.

Claimant's record also showed non-exertional limitations. Claimant testified that he had memory and concentration issues and tried not to cook because he would forget that he put things on the stove. He did not shop or launder for himself, usually having a family member or neighbor do it for him. He did not have a drivers' license and did not like to drive since his 2007 auto accident. He complained that he heard whispering voices and saw things flying at night.

The August 2012 psychiatric evaluation diagnosed Claimant with major depressive disorder, recurrent severe with psychotic features, and the August 2013 consulting exam diagnosed Claimant with mood disorder and chronic alcohol dependence and personality disorder. However, there was no medical evidence presented that his mental condition resulted in a marked or even moderate limitations in his ability to perform basic work activities. Furthermore, the consulting doctor who performed the August 2013 psychiatric exam noted that Claimant's responses indicated malingering. There were also inconsistencies in Claimant's testimony on the record. Claimant testified that he had trouble swallowing and had lost weight but the medical evidence showing that his weight at the hearing was within the range reported in his January 2013 physical exam. His testimony that he had no friends was also inconsistent with his testimony that he had a nurse friend and social interactions with his neighbors. It is further noted that in the August 22, 2013, exam Claimant reported that he had a radiologist girlfriend, calling to question his testimony that his nurse friend was his brother's friend's girlfriend.

In light of the inconsistencies in Claimant's testimony, which call to question his credibility, and the limited medical evidence to support physical and mental limitations on Claimant's ability to perform work activities, the restriction on Claimant's RFC is, at most, mild to moderate.

**Step Four**

The fourth step in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). 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). An individual who has the RFC to meet the physical and mental

demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. 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).

Claimant's prior work history consists of work as a truck driver. Claimant's mild to moderate limitations with respect to his mental RFC and his fear of driving in light of his severe 2007 auto accident render him unable to return to this previous work. Although there was also evidence that Claimant was employed at Tim Horton's and as a housekeeper, this employment appears significantly limited and would not constitute significant gainful activity. As such, it was not past relevant employment for consideration under step 4.

Because Claimant cannot be found disabled, or not disabled, at step 4, the disability analysis proceeds to step 5.

**Step 5**

In step 5, an assessment of Claimant's RFC 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 this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the RFC to obtain and maintain 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). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work. *Id.*

In this case, Claimant has a GED and a mental RFC showing, and most, mild to moderate limitations in his mental ability to perform basic work activities. Claimant's circumstances would not seriously affect his ability to adjust to other work. Accordingly, after review of the entire record and in consideration of Claimant's age, education, work experience, and RFC, Claimant is found **not** disabled at Step 5.

A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or

blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program. BEM 261 (July 2013), p. 2.

In this case, Claimant is found not disabled for purposes of the MA-P program and, therefore, not disabled for purposes of SDA benefit program.

## DECISION AND ORDER

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

Accordingly, It is ORDERED that the Department's determination is AFFIRMED.

**Alice C. Elkin**
Administrative Law Judge
For Maura Corrigan, Director
Department of Human Services

Date Signed: May 16, 2014

Date Mailed: May 16, 2014

**NOTICE OF APPEAL:** The claimant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely Request for Rehearing or Reconsideration was made, within 30 days of the receipt date of the Decision and Order of Reconsideration or Rehearing Decision.

Michigan Administrative Hearing System (MAHS) 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. MAHS 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 (60 days for FAP cases).

A Request for Rehearing or Reconsideration may be granted when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The Department, AHR or the claimant must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date the hearing decision is mailed.

The written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-07322

ACE/tlf

cc: [redacted]