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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-009616
Issue No.: 2009
Case No.: [redacted]
Hearing Date: October 9, 2014
County: Jackson

ADMINISTRATIVE LAW JUDGE: Vicki Armstrong

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 4-way telephone hearing was held on October 9, 2014, from Lansing, Michigan. Claimant, represented by [redacted] of [redacted], personally appeared and testified. Participants on behalf of the Department of Human Services (Department) included Family Independence Manager [redacted] and Assistant Attorney General [redacted].

During the hearing, Claimant submitted additional medical evidence. This matter is now before the undersigned for a final decision.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) 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 February 10, 2014, Claimant filed an application for MA/Retro-MA benefits alleging disability.

(2) On May 14, 2014, the Medical Review Team (MRT) denied Claimant's application for MA-P/Retro-MA for lack of duration. (Dept Ex. A, pp 11-12).

(3) On June 10, 20114, the Department sent Claimant notice that his application was denied.

(4) On December 13, 2013, Claimant filed a request for a hearing to contest the Department's negative action.

(5) Claimant has a history of lymphoma in remission, gout, epilepsy, depression and bipolar disorder.

(6) Claimant is a 49 year old man whose birthday is [redacted].

(7) Claimant is 5'5" tall and weighs over 163 lbs.

(8) Claimant has a tenth grade education.

(9) Claimant is scheduled for a Social Security disability benefits hearing for November 20, 2014.

CONCLUSIONS OF LAW

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

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Family Independence Agency) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

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).

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).

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, Appendix 1, 12.00(C).

As outlined above, the first step looks at the individual's current work activity. In the record presented, Claimant has never been involved in substantial gainful activity. Therefore, he 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 a history of lymphoma in remission, gout, epilepsy, depression and bipolar disorder. As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). Based on the medical evidence, Claimant has presented some limited medical evidence establishing that he does have some mental limitations on his 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 the 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.

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).

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.

Claimant has a history of less than gainful employment. As such, there is no past work for Claimant to perform, nor are there past work skills to transfer to other work occupations. Accordingly, Step 5 of the sequential analysis is required.

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, Claimant was 49 years old and was, thus, considered to be a younger individual for MA-P purposes. Claimant has a tenth grade education. 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).

In this case, the evidence reveals that Claimant suffers from lymphoma currently in remission, gout, epilepsy, depression and bipolar disorder.

Claimant testified that he can walk a couple of blocks, stand for five minutes, sit for 30-45 minutes and lift and carry approximately 10 pounds. Claimant states he does not smoke, drinks a beer a couple of times a week and does not have an alcohol or drug history. Claimant reported that he is compliant with his medications, but that his anti-depressant medications are not controlling his mood swings.

Claimant was transported by ambulance to the emergency department on [redacted], [redacted] complaining of neck pain, stating he had three seizures today, "close up together." Claimant stated he has been taking his seizure meds but is still having seizures daily. He also stated he is out of Norco's and Lorecet's from [redacted]. He complained of chronic pain and said he took his last Norco that afternoon. No current seizure activity was noted. He was not postictal. He did not bite his tongue. He was well developed, well nourished, and in no acute distress. Respiration was easy and non-labored. Skin within normal limits and he was alert and oriented. Musculoskeletal

exam showed normal strength and range of motion. He ambulates in the room with a steady gait. No swelling or tenderness. Dilantin level is borderline therapeutic in the low tens.

On [redacted], Claimant established care with [redacted] for hypertension, cough and gout. Claimant was well developed and oriented to time, place, person and situation. [redacted] ordered further diagnostic evaluations and referred Claimant to a neurologist to evaluate and treat his epilepsy.

Claimant completed the Activities of Daily Living form on [redacted]. Claimant admitted to vacuuming, doing the dishes and shoveling snow. Claimant added that since his illness, he now requires more time to complete tasks especially snow shoveling. During the hearing, Claimant vehemently denied shoveling snow, bringing his credibility into question.

X-rays of Claimant's lumbosacral spine on [redacted], showed no acute osseous abnormality and minimal dextroscoliosis and mild facet degenerative changes at L5-S1. No evidence of spondylolysis or spondylolisthesis.

X-rays on [redacted], of Claimant's lumbosacral spine revealed no acute lumbosacral abnormality and no appreciable change since the [redacted] exam. There was a mild degree of dextro rotatory scoliosis and minimal degenerative change of the facet joints at L4-L5-S1 levels, otherwise no significant abnormality. The SI joints and hip joints appeared unremarkable.

On [redacted], Claimant saw [redacted] for medication refills. [redacted] indicated Claimant was seeing multiple doctors in the last couple of months for his Norco 10/325 mg. His maps showed that he had been to multiple facilities for pain medication. [redacted] discussed with him that the center of family health has a policy with people going to multiple providers for the narcotics and that he would not be prescribing anymore pain medication for him. Claimant stated he understood but he was not happy with the news. X-ray of the back showed mild degeneration of disc and mild wear and tear of facets. [redacted] also completed a Medical Examination Report on behalf of the Department. Claimant is diagnosed with a seizure disorder, back pain, and hypertension. [redacted] refused to complete the physical limitation section indicating Claimant needed a functional evaluation for the completion of that section. [redacted] did indicate Claimant had no mental limitations and was able to meet his own needs in the home.

Claimant's CT pulmonary angiogram on [redacted], was negative with no evidence of a pulmonary embolism.

Claimant followed up with [redacted] on [redacted]. Claimant has been scheduled to see a neurologist in December, 2014, at the [redacted]. Claimant states he is still having seizures three times a week, even on Dilantin and Keppra. Claimant was instructed to take Ativan for his seizures only and was given 10 tablets. Claimant requested pain medication, but [redacted] indicated Claimant is getting it from another provider and he did not feel comfortable giving him any more narcotics for back pain.

On [redacted], Claimant met with his psychiatrist. The psychiatrist indicated Claimant presented him with forms to complete for the Department. The psychiatrist referred Claimant to a copy of the psychiatric evaluation and the one medical review. The psychiatrist explained the need for a more extensive assessment before he would complete the forms. Claimant stated he was not sleeping and that the medications were ineffective, including Amitriptyline and Prazosin. He said he has been hallucinating for the past four months. The psychiatrist noted Claimant was a poor historian and did not disclose many of the symptoms unless the psychiatrist confronted him with the notes of the nurse. Claimant appears to be otherwise logical. Claimant said he had a seizure two weeks ago and complained of feeling tired during the day. Claimant's affect was constricted. The psychiatrist indicated a longitudinal study was needed to clarify Claimant's diagnosis, which was pending awaiting Claimant's previous medical records.

Claimant's counselor and social worker completed the Psychiatric/Psychological Examination Report on behalf of the Department on [redacted]. Claimant was diagnosed with posttraumatic stress disorder, sleep disturbance, nightmares/flashbacks, hypervigilance, irritability, restricted affect and difficulty focusing. The social worker indicated Claimant has poor insight and significant impairment in activities of daily living. Diagnosis: Axis I: Mood disorder; Posttraumatic stress disorder; Learning disorder; Axis II: N/A: Axis III: Epilepsy, Lupus, Gout, Chronic Back Pain, Migraines; Axis IV: Inadequate finances, Parole; Axis V: GAF=45 current, 40 last year. According to his Mental Residual Functional Capacity Assessment, Claimant was markedly limited in his ability to understand and remember detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; and complete a normal workday and worksheet without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods. This evidence is given little weight due to the conflicting diagnoses and conclusions when compared with other medical records, as well as the fact that the evaluation was not completed by a physician.

On [redacted], Claimant was taken to the emergency department by ambulance. On arrival there was no current seizure activity notes. He was not postictal and did not bite his tongue. He was well-developed, well-nourished, well-groomed, cooperative, with normal speech, alert and awake. He was in no acute respiratory distress with normal nonlabored respirations. Claimant stated he had 2 seizures that morning and is having 2-3 seizures per week. He is taking Keppra, Dilantin and Lorazepam. He stated he is taking his medication as prescribed. Claimant also complained of back pain. He denied any numbness or tingling. Denied any loss of bowel or bladder control. He said he was recently diagnosed with lymphoma in his lungs. He is not on any chemotherapy. History comes from Claimant. He has upper back pain, mid back pain, lower back pain and lateral neck pain. On examination, Claimant did not appear acutely ill or toxic. Neck was supple without significant adenopathy or mass. He was alert and oriented to person, place and time. He responded appropriately to questions. His recent memory was intact. Good neck muscle tone. He had normal strength and range of motion. He had tenderness to palpation of the bilateral paraspinous muscles of the cervical, thoracic and lumbar spine. Lab work showed Claimant's Dilantin level was subtherapeutic. Claimant was given a dose of Dilantin, Motrin and Norflex. He was

discharged home with Naprosyn. Claimant's discharge diagnosis was seizure, backache and strain of neck muscle.

Claimant presented to the emergency department on [redacted], after experiencing two seizures. Claimant was taking antiepileptic medication and denied ever missing any doses or having any recent dosage changes. Labs were drawn and were significant only for an apparent subtherapeutic Dilantin level. This was discussed with Claimant who stated that he has been taking his Dilantin as prescribed and he had only missed the evening's dose because of the seizure. Claimant's low Dilantin level was discussed with the pharmacist who stated it was not clear why Claimant would have a subtherapeutic and essentially undetected Dilantin level if he had been taking his medications as prescribed. Claimant was given an infusion of fosphenytoin as well as his normal home dose of Norco. He was discharged in stable condition.

On [redacted], Claimant was transported to the emergency department by ambulance, after complaining of vomiting blood. Nursing assessment found Claimant to be well-developed, well-nourished, well-groomed, cooperative, normal speech, alert, awake with an appropriate affect. He had a normal nondistended abdomen, soft, non-tender abdomen. Claimant stated he had abdominal pain while vomiting but none was present during the assessment. On exam, Claimant was alert and did not appear acutely ill or toxic. His neck was supple with no crepitus. His abdomen was soft, nontender, nondistended with no palpable masses and normal bowel sounds. He had normal strength and range of motion. No swelling, no tenderness. The examining physician noted Claimant had multiple risk factors for pulmonary embolism, but his exam was benign. Laboratory workup was normal. The CT revealed no pulmonary embolism or aortic dissection. Negative CT angiography of the chest. Evidence of old granulomatous on the left. On comparison with the prior exam of [redacted], there was no significant interval change. Discharge diagnosis was hematemesis.

On [redacted], Claimant saw [redacted] for a flu vaccine. Claimant indicated his symptoms were mild and he would like a refill of his medications. [redacted] indicated Claimant did not know what he was on and called his wife. Claimant said he needed a refill on blood pressure medication, inhalers and Norco for his chronic back pain. Claimant stated his bones were fused together at birth and he was in a car accident in 1994. Claimant was willing to sign a contract. He last took Norco two months ago and Ativan three weeks ago. Claimant denied using street drugs including marijuana.

Claimant returned to see [redacted] on [redacted], and received a refill of Norco.

Claimant presented to the emergency department on [redacted], stating he had had two seizures earlier that day. He also noted he had been having back pain. He stated he missed a dose of Dilantin yesterday. On exam, he looked mildly uncomfortable most likely related to exacerbation of his chronic back pain. Claimant was given an extra dose of Dilantin as well as some pain medication. He was discharged home.

Claimant attended a medication review with his psychiatrist on [redacted]. Claimant complained he is not sleeping at all in spite of the Amitriptyline and Prazosin. He feels tired all the time and has racing thoughts. The psychiatrist indicated Claimant is pursuing social security disability. He came in with a cane and was ambulatory and

fluent. He was alert and oriented, otherwise, quiet and nondescriptive. Claimant told the psychiatrist he still has seizures resulting in trips to the emergency room a couple of times. He appeared to be logical. There was no pressured speech and no flight of ideas. He told the psychiatrist that his lymphoma was worsening and he is facing chemotherapy. Claimant said he had refused it before out of fear for the side effects that he witnessed in a friend. He had no delusions or hallucinations. Claimant had a history of substance abuse with legal consequences, seizure disorder, chronic pain, hypertension, COPD, dyslipidemia, history of stroke and history of head injuries.

On [redacted], Claimant's CT head or brain with and without contrast due to a head injury, was normal with no intracranial injury, no mass or anatomic seizure focus evident.

Claimant's counselor completed Diagnostic Information on [redacted]. Axis I: Posttraumatic stress disorder; Axis II: Learning disorder, NOS; Axis III: Hodgkin's lymphoma, epilepsy, lupus, chronic back pain, gout, hypertension, high cholesterol and a history of heart attack; Axis IV: occupational problems, economic problems and problems related to the legal system/crime. He was unemployed, had inadequate finances and on parole for possession of cocaine and marijuana. Axis V: GAF=38. The counselor noted Claimant was appropriately dressed, of average intelligence and communicated normally. He was cooperative, with a restricted affect. He was logical with unremarkable thought content or perceptions. He was alert and oriented to person, place, and time. He had fair insight and a good/normal memory. He was intact with reality. Claimant stated he attempted to overdose on prescription medication in 2001. No current suicidal ideation reported.

On [redacted], an MRI of Claimant's lumbar spine for lumbago was normal. The MRI of the thoracic spine showed nonspecific signal abnormalities in the lower cervical cord, likely representing gliosis. No abnormality of the thoracic spine or cord.

Claimant was referred to an oncologist for an evaluation concerning his shortness of breath, sarcoidosis and whether it was lymphoma or not and any evidence of active inflammatory illness. Claimant had an overnight pulse oximetry. There was no variation of his pulse rate which was generally about 70. He appeared to have 2 episodes where he awoke and had a temporary increase in his pulse. His pulse oximetry was between 90% and 95%. A CT of the head showed no obvious evidence of major structural damage to the brain. The oncologist reviewed Claimant's medical records and found it was unclear whether Claimant has had bonafide seizures or pseudoseizures. Claimant's CAT scans were reviewed extensively and there was no obvious evidence of lymphoma, lymphadenopathy, or active sarcoidosis. There was an old left upper lobe granuloma. Vascular studies of the pulmonary arteries show no obvious evidence of pulmonary hypertension, or chronic pulmonary embolism. There is no evidence of inflammatory illness. The oncologist opined Claimant has marked symptoms but few findings objectively of active inflammatory or neoplastic disease.

During the hearing, Claimant presented a typed letter dated [redacted], signed by [redacted], on letterhead from [redacted]. The letter indicated Claimant was a client and had been receiving individual and group services through the clinic since 2009. According to the letter, Claimant has been diagnosed

with posttraumatic stress disorder and a learning disability. The letter indicated that due to Claimant's PTSD symptoms, significant health issues (epilepsy, lupus, chronic back pain, gout, etc.), Claimant is unable to work.

In light of the foregoing and the lack of medical objective substantiation for the majority of Claimant's subjective complaints, in addition to his questionable credibility and medication compliance, it is found that 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 202.17**,** it is found that Claimant is not disabled for purposes of the MA-P program at Step 5.

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 benefit programs.

Accordingly, it is ORDERED:

The Department's determination is **AFFIRMED**.

Vicki Armstrong
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **10/13/2014**

Date Mailed: **10/13/2014**

Vla/las

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration 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 party requesting a rehearing or reconsideration 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 this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, 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

cc: [redacted]