

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

IN THE MATTER OF:

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██████████████████

Reg. No.: 14-011226
Issue No.: 4009
Case No.: ██████████
Hearing Date: November 13, 2014
County: Wayne-District 57

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, an in-person hearing was held on November 13, 2014, from Detroit, Michigan. Claimant appeared and testified on his behalf. ██████████, Eligibility Specialist, appeared and testified on behalf of the Department of Human Services (Department).

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

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 3, 2014, Claimant submitted an application for public assistance seeking SDA benefits.
2. On August 13, 2014, the Medical Review Team (MRT) found Claimant not disabled.
3. On August 25, 2014, the Department sent Claimant a Notice of Case Action denying the application based on MRT's finding of no disability.
4. On September 3, 2014, the Department received Claimant's timely written request for hearing.
5. Claimant alleged physical disabling impairment due to asthma and hypertension.

6. Claimant alleged mental disabling impairment due to anxiety.
7. On the date of the hearing, Claimant was [REDACTED] years old with a [REDACTED], birth date; he is [REDACTED] in height and weighs [REDACTED] pounds.
8. Claimant graduated from high school.
9. Claimant has an employment history of work as (i) a window factor assembler, (ii) a used appliance salesperson; and (iii) a stockperson at a grocery store.
10. Claimant's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

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 State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

A disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

To determine whether an individual is disabled for SSI purposes, the trier of fact must apply a five-step sequential evaluation process and consider the following:

- (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)(1) and (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 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 for SDA 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 90 days. 20 CFR 416.922; BEM 261, p. 2.

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). Basic work activities mean 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. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, 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 v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985).

In the present case, Claimant alleges physical disabling impairment due to asthma and hypertension and mental disabling impairment due to anxiety. The medical evidence presented at the hearing was reviewed and is summarized below.

On May 14, 2013, Claimant went to the emergency department with complaints of a rash on his back, chest and face. He was diagnosed with eczema, prescribed medication, and released. (Ex 4, pp. 48, 53.)

On May 28, 2013, Claimant went to the emergency department with complaints of vomiting, chest tightening, and sore throat (Ex 4, pp. 40-42). An x-ray of the abdomen showed no consolidation or convincing GI obstruction or free air, and an ultrasound of his abdomen showed fatty infiltration of the liver but no findings of cholelithiasis or acute cholecystitis. (Ex 4, pp. 46-47, 59-60.)

On February 24, 2014, ██████████ evaluated Claimant's mental condition and completed a psychiatric/psychological examination report, DHS-49-D. In his mental examination of Claimant, the doctor noted that Claimant was anxious, tense and somewhat restless. Claimant reported multiple deaths of close family and friends since December 2012 and indicated that he was depressed, suffering from nightmares and experiencing episodes of nausea and vomiting. The doctor noted that Claimant's affect was constricted, his speech spontaneous and coherent, his memory was intact but his judgment was marginal to fair and he had impaired concentration and focus. The doctor noted that Claimant reported that he lived with his mother and his anxiety kept him at home and that he took care of his own hygiene and grooming but he was helped by his mother with cleaning and cooking. The doctor diagnosed Claimant with post-traumatic stress disorder/general anxiety disorder, noting that he had moderate to severe psychosocial/environmental stressors. He concluded that Claimant's global functioning assessment score was 43, and last year was between 40 and 50. (Ex 4, pp. 63-64).

██████████ also completed a mental functional capacity assessment on February 28, 2014. He concluded that Claimant had no significant to moderate limitations regarding

his ability to (i) understand and remember one or two-step instructions; (ii) carry out simple one or two step instructions; (iii) ask simple questions or request assistance; and (iv) be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Claimant had moderate limitations regarding his ability to (i) remember locations and work-like procedures; (ii) perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (iii) sustain an ordinary routine without supervision; (iv) work in coordination with or proximity of others without being distracted by them; (v) make simple work-related decision; (vi) interact appropriately with the general public; (vii) get along with co-workers or peers without distracting them or exhibiting behavioral extremes; (viii) maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; (ix) respond appropriately to change in the work setting; (x) travel in unfamiliar places or use public transportation. The psychiatrist concluded that Claimant had moderate to marked limitations regarding his ability to (i) maintain attention and concentration for extended periods; (ii) complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; (iii) accept instructions and respond appropriately to criticisms from supervisors; and (iv) set realistic goals or make plans independently of others. The doctor concluded that Claimant had marked limitations regarding his ability to understand and remember detailed instructions and carry out detailed instructions. (Ex 4, pp. 65-66.)

On June 14, 2014, Claimant's treating physician completed a medical examination report, DHS-49, indicating that Claimant suffered from asthma, hypertension, back pain and psychiatric disorder and had high body mass index. In his physical exam, the doctor noted lumbar tenderness and bilateral knee tenderness. The doctor concluded that Claimant was in stable condition but noted the following physical limitations: (i) he could frequently lift up to 10 pounds, occasionally lift 10 pounds and never lift 20 pounds or more; and (ii) he could use both arms/hands for simple grasping, reaching, and fine manipulating but never for pushing/pulling. The doctor found no limitations to Claimant's use of his feet or legs. Although the doctor marked Claimant as having mental limitations, he did not identify what those limitations were. (Exhibit 4, pp. 18-20.)

Claimant's treating physician provided his notes from Claimant's office visits from February 4, 2014 to July 8, 2014 (Ex 4, pp. 25-32). On February 4 and 25, 2014, Claimant complained of lower back pain and difficulty sitting after he fell on his buttocks when slipping on ice and the doctor noted abnormalities upon palpitation of the lumbosacral spine (Ex4, pp. 30-32). On March 25, 2014, the doctor noted elevated blood pressure and advised Claimant that he needed to begin medication to treat his elevated blood pressure (Ex 4, p. 30). In response to Claimant's complaints of abdominal pain and constipation on April 22, 2014, the doctor advised dietary changes (Ex 4, p. 29). In his May 22, 2014, records, the doctor reported that Claimant complained of back and left knee pain following a motor vehicle accident the previous month; the doctor noted tenderness on palpitation of the back and knee abnormality and tenderness and referred Claimant for x-rays (Ex 4, p. 28). A June 26, 2014 x-ray of

Claimant's thoracic spine showed no acutely displaced fracture or subluxation of the thoracic spine; an x-ray of his thoracolumbar spine showed no fracture, compression deformity of spondylolisthesis; and an x-ray of his left knee was normal (Ex 4, pp. 34-37). In his June 24, 2014 notes, the doctor described that Claimant was treated with regular use of maintenance inhaler and, if necessary, nebulizer treatments and oxygen therapy. With respect to his hypertension, the doctor instructed Claimant to comply with his medication, manage his weight, exercise regularly, maintain a low sodium diet, monitor his blood pressure at home regularly, and avoid tobacco. (Ex 4, p. 27). In his notes from Claimant's July 8, 2014 visit, the doctor notes that Claimant's pulmonary functional test results from May were mild/not significant but he was prescribed medication to treat his asthma. The doctor noted that Claimant had a secondary motive of trying to get disability. (Ex 4, p. 26-32.)

In consideration of the *de minimus* 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 90 days. 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 alleges physical disabling impairment due to asthma and hypertension and mental disabling impairment due to anxiety, which the doctor diagnosed as post-traumatic stress disorder/generalized anxiety disorder. Based on the objective medical evidence of asthma, Listing 3.00 (respiratory system), particularly 3.03 (asthma) was reviewed. Because there were no medical test results establishing chronic obstructive pulmonary disease under 3.02A or, despite prescribed treatment, attacks occurring at least once every 2 months or at least six times a year requiring physician intervention, Claimant's medical record in this case is not sufficient to support a finding that his asthma meets a listing under 3.03.

With respect to Claimant's diagnosis of, and treatment for, hypertension, Listing 4.00 (cardiovascular system) was reviewed. Because Claimant's record does not show that Claimant's condition was not being controlled with medication, Claimant's hypertension does not meet, or equal, a listing to qualify as disabling.

Claimant's mental disabling impairment due to anxiety, which the doctor diagnosed as post-traumatic stress disorder/generalized anxiety disorder, was reviewed under 12.00 (mental disorders), particularly 12.06 (anxiety-related disorders). Claimant's record

does not establish medically documented findings of either (i) generalized persistent anxiety with three of the four signs or symptoms of motor tension, autonomic hyperactivity, apprehensive expectation, or vigilance and scanning; (ii) a persistent irrational fear of a specific object, activity or situation; (iii) recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; (iv) recurrent obsessions or compulsions which are a source of marked distress; or (iv) recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress. Therefore, Claimant's mental condition does not meet, or equal, a listing under 12.06.

Because the evidence does **not** show that Claimant's impairments due to his hypertension, asthma or hypertension meet, or are equal to, the required level of severity of a listing to be considered as disabling without further consideration, 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 RFC takes into consideration the total limiting effects of all impairments, including those that are not severe. 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, nonexertional, 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). To

determine the exertional requirements, or physical demands, of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a).

Sedentary work.

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

Light work.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 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. If someone can do light work, . . . he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

Medium work.

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, . . . he or she can also do sedentary and light work.

Heavy work.

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

Very heavy work.

Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, . . . he or she can also do heavy, medium, light, and sedentary work. 20 CFR 416.967.

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 nonexertional 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).

In this case, Claimant alleges both exertional and nonexertional limitations due to his medical condition.

Claimant testified that he had few physical restrictions with respect to his ability to walk, sit, lift, bend, squat, stand, grip or grasp. He indicated that he could not run due to his asthma and that he could lift 40 pounds but his anxiety would keep him from lifting any additional weight. He testified that he lived with his mother and she cooked and cleaned. He could not do his laundry because he had difficulty with the stairs due to his asthma. He testified that he could bath and dress himself. He did not drive and he avoided large crowds because it triggered his anxiety.

Claimant explained that his anxiety resulted from the loss of several close family and friends between April 2013 and December 2013. He testified that his anxiety initially manifested itself in daily panic attacks, nightmares and vomiting. He was referred to the [REDACTED] by the emergency department who indicated that his vomiting and abdominal pain was due to anxiety. He testified that he experienced panic attacks on a daily basis lasting an hour to an hour and a-half. His mental condition has affected his memory and concentration. He also experiences poor sleep, sleeping from 10 pm to 5 am and then being unable to go back to sleep. He also experienced headaches.

Claimant's medical record from his treating primary care physician showed that Claimant had asthma and was being treated with inhalers and other treated with regular use of maintenance inhaler and, if necessary, nebulizer treatments and oxygen therapy. The doctor's notes also show that Claimant's pulmonary functional test results from May 2014 were mild/not significant. (Ex 4, p. 25-32.) With respect to his high blood pressure, the doctor prescribed medication and instructed Claimant to comply with his medication, manage his weight, exercise regularly, maintain a low sodium diet, monitor his blood pressure at home regularly, and avoid tobacco (Ex 4, pp. 27, 30). The doctor's notes from office visits indicate that Claimant had ongoing complaints of knee and back pain following a fall but a June 26, 2014 x-ray of Claimant's thoracic spine showed no acutely displaced fracture or subluxation of the thoracic spine; an x-ray of his thoracolumbar spine showed no fracture, compression deformity of spondylolisthesis; and an x-ray of his left knee was normal (Ex 4, pp. 26-32, 34-37).

On June 14, 2014, Claimant's treating physician completed a medical examination report, DHS-49, indicating that Claimant suffered from high body mass index, asthma, hypertension, back pain and psychiatric disorder. In his physical exam, the doctor noted lumbar tenderness and bilateral knee tenderness. The doctor concluded that Claimant was in stable condition but noted the following physical limitations: (i) he could frequently lift up to 10 pounds, occasionally lift 10 pounds and never lift 20 pounds or more; (ii) he could use both arms/hands for simple grasping, reaching, and fine manipulating but never for pushing/pulling. The doctor found no limitations to Claimant's use of his feet or legs. Although the doctor marked Claimant as having mental limitations, he did not identify what those limitations were. (Exhibit 4, pp. 18-20.)

Although Claimant testified that he could lift up to 40 pounds, based on the limited physical restrictions reflected by Claimant's medical records, particularly his treating

doctor's restrictions, Claimant maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

Claimant also alleged nonexertional limitations due to his mental condition. For mental disorders, 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). In addition, 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.*

In the February 24, 2014, psychiatric/psychological examination report, DHS-49-D, the psychiatrist concluded that, based on the deaths of close family and friends Claimant reported, he suffered from post-traumatic stress disorder/general anxiety disorder with moderate to severe psycho-social/environmental stressors. The doctor noted that Claimant's affect was constricted, his speech spontaneous and coherent, his memory was intact but his judgment was marginal to fair and he had impaired concentration and focus. He concluded that Claimant's GAF score was 43. (Ex 4, pp. 63-64). A review of the mental residual functional capacity assessment the doctor completed on February 28, 2014, shows that, overall, Claimant was moderately limited with respect to his understanding and memory, sustained concentration and persistence, social interaction, and adaptation (Ex 4, pp. 65-66). Based on the medical record presented, as well as Claimant's testimony, Claimant has moderate limitations on his mental ability to perform basic work activities.

Claimant's RFC is considered at both steps four and five. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 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).

As determined in the RFC analysis above, Claimant is limited to no more than light work activities and has moderate limitations in his mental capacity to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as a window factor assembler (medium, semi-skilled); a used-appliance salesperson (heavy, unskilled), and a stockperson at a grocery store (medium, unskilled). In light of the entire record and Claimant's RFC, particularly his physical limitations, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues 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). 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.

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).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the nonexertional aspects of work-related activities Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, 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). When a person has a combination of exertional and nonexertional 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, at the time of hearing, Claimant was [REDACTED] years old and, thus, considered to be a younger individual (age 18-44) under the Medical-Vocational guidelines. He is a high school graduate with a history of unskilled and semi-skilled work experience. As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities and has moderate limitations on his mental ability to perform work activities. The Medical-Vocational Guidelines do not result in a disability finding based on Claimant's exertional limitations. Therefore, the issue of whether Claimant's mental limitations limit his ability to perform basic work activities is considered. Claimant's medical record shows

nonexertional limitations resulting in moderate restrictions in his ability to perform basic work activities. The limitations cited in the February 28, 2014 mental residual functional capacity assessment show that, while Claimant has marked limitations in his ability to understand and carry out detailed instructions, he has only moderate limitations on his ability to carry out simple one and two-step instructions and to work in coordination with or proximity to others without being distracted by them and to make simple work-related decisions. In light of the entire record and Claimant's RFC, including his mental limitations, it is found that Claimant is able to perform basic work activities. Accordingly, Claimant is found **not** disabled, at Step 5 for purposes of SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant not disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is AFFIRMED.



Alice Elkin

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

Date Signed: **12/4/2014**

Date Mailed: **12/4/2014**

ACE / tlf

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 48909-8139

CC:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]