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

IN THE MATTER OF:

[redacted]

Reg. No.: 14-014170
Issue No.: 2009
Case No.: [redacted]
Hearing Date: December 10, 2014
County: WAYNE-DISTRICT 18 (TAYLOR)

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 three way hearing was held on December 10, 2014, from Detroit, Michigan. Participants on behalf of Claimant included the Claimant. [redacted] the Claimant's Authorized Hearing Representative, also appeared. Participants on behalf of the Department of Human Services (Department) included [redacted], Medical Contact Worker.

ISSUE

Whether the Department properly determined that Claimant was not disabled for purposes of the Medical Assistance (MA) and/or 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. The Claimant applied for MA-P on April 10, 2014 with a retro application for February 2014.

2. The Medical Review Team denied Claimant's request on July 25, 2014.

3. The Department sent the Claimant a Notice of Case Action on July 29, 2014.

4. The Claimant's AHR filed a timely hearing request on October 1, 2014.

5. An interim order was issued on December 10, 2014 requesting the Claimant obtain a DHS 49 and treatment records from his family practice doctor. The medical evidence was provided.

6. The Claimant has alleged physical disabling impairments which include COPD, hypertension, and sacroiliitis, hypertension, chronic neck pain or cervicalgia, back pain, and hypercholesterolemia.

7. The Claimant has alleged mental disabling impairments including depression. The Claimant has not received any outpatient treatment.

8. The Claimant's past relevant work was as a carpenter, and as a window installer. The Claimant completed the 10th grade and completed a GED.

9. At the time of the hearing the Claimant was [redacted] years old with an [redacted] birth date. The Claimant was 5'8" and weighed 185 pounds.

10. The Claimant's impairments have lasted or are expected to last for 12 months' duration on 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 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.

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 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.

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

As outlined above, the first step looks at the individual's current work activity. In the record presented, the Claimant is not involved in substantial gainful activity and, therefore, is not ineligible for disability benefits under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant 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 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).

The Claimant has alleged physical disabling impairments which include COPD, hypertension, sacroiliitis, chronic neck pain or cervicalgia, back pain, and hypercholesterolemia.

The Claimant has alleged mental disabling impairments including depression. The Claimant has not received any outpatient treatment.

A summary of the medical evidence provided follows.

On [redacted] the Claimant was seen at the ER with a rib injury and alcohol intoxication. The report indicates that Claimant was assaulted by three men due to an altercation and was hit and kicked. The Claimant had a small laceration to his head and complaint of rib injury. Claimant arrived at ER by EMS. There was no report of numbness, no abdominal pain, no nausea/vomiting, no neck pain, no focal weakness, no decreased responsiveness, no lightheadedness, no loss of consciousness, no seizures, no tingling, no weakness, no cough and no memory loss. The reported history included COPD, hypertension, depression, alcoholism, history of narcotic use and chronic low back pain. An exam revealed left lower rib pain and headaches and positive for back pain. A chest x-ray noted an acute mildly displaced rib fracture on the left at rib 7, remainder of the chest is without acute process. A CT of the head was also performed with the impression no acute intracranial process, mild paranasal sinus disease with no acute intracranial hemorrhage. The Claimant was to be discharged home when clinically sober and was prescribed Augmentin for sinusitis. The blood alcohol value was 302 with a reference range of less than 5 mg/dl. The presenting problems were rated as moderate.

The Claimant was seen again the next day in the ER with continued complaints of increased pain. The history noted alcohol use, one-fifth of whiskey daily. The report notes that the Claimant had not taken his blood pressure meds in four months. The Claimant was discharged after given medications in ER Department and referred to follow up with primary care provider with referrals made.

The Claimant's family practice doctor who began seeing the Claimant in [redacted] completed a DHS 49 Medical Exam Report on [redacted]. The diagnosis was COPD, hypertension, hypotension, depression, back pain and sacroiliitis. The doctor noted that the Claimant could stand and/or walk about 6 hours in an 8-hour work day and sit about 6 hours in an 8-hour work day. The doctor rated Claimant as stable and indicated that he could frequently lift up to 25 pounds and occasionally 50 pounds or more. Claimant had full use of both hands/arms and could operate foot/leg controls with both feet. No mental limitations were noted. The Claimant could meet his needs in the home.

When the Claimant was first seen by this doctor in [redacted] the active problems were sacroiliitis, hypertension, COPD, neck pain or cervicalgia, hypercholesterolemia, depressive disorder. At that time Claimant told the doctor he had three drinks per week. At the time of the initial exam and screening the Claimant was advised to stop smoking immediately and cautioned not to just cut down. or he not quit smoking. The instruction sheet advised the Claimant where he might get a free smokers quit kit, and possible free nicotine patch. The doctor's notes indicated that problems were blood pressure,

back pain and breathing. The notes indicate that the neck pain started in [redacted] after a fall with popping and cracking sounds. An alcohol screening test was performed and the notes indicated that he felt no need to cut down on drinking. The doctor noted mild depression. At the time the Claimant was injected in the sacroiliac bilateral joints, as well as trapezius muscles bilateral trigger point injection. When seen again on [redacted] for follow up, he had neck pain on the left superior trapezius, with some pain in the lower C spine.

The Claimant was seen a month later and the diagnosis was the same with the addition of back pain. The Claimant was prescribed Norco, Flexeril, Daypro, Lamisil cream and Terazosin. On [redacted] the Claimant was sent for a consult to a general and colorectal surgeon for a colonoscopy. In November the Claimant was to be seen with a registered dietitian and exercise coach for chronic pain and hypertension. The Claimant was seen on [redacted] and was again to be seen by an exercise coach and dietician for COPD, depression and hypertension. The Claimant was prescribed and inhaler for wheezing.

On [redacted] the Claimant reported improved mood, sleeping well, feels better, and son notes change in his mood, not as angry. Urinary urgency also improved. The exam was normal except for congested bilateral nostrils, drainage in mouth and tenderness left mid-trapezius. The Claimant received trigger point injection in left trapezius and another injection cortisteroid injection in his neck. The Claimant smokes two packs a day. Repeat injections were given on [redacted].

In [redacted] the Claimant was seen and received injections in the trapezius and in his neck. At the next December visit on [redacted] the Claimant indicated he could walk six blocks before having to stop due to shortness of breath and he does not walk very often any more. The pulmonary function test was reviewed, and noted mild obstruction. The exam report was filled out with the Claimant's help (DHS 49). An x-ray of the chest noted lungs and pleural spaces are clear with noted right rib fractures on right 8th rib. (See reference above).

A consultative medical examination was completed [redacted]. Chief complaints were hypertension, COPD, chronic back pain and neck pain and depression. The respiratory exam noted no abnormalities, no wheezes, rales or rhonchi and no cough. Noted mild tenderness to palpation in the paracervical and paralumbar areas. No muscle spasm. The examiner noted that Claimant got on and off table and heel toe walked slowly. The Claimant was able to squat 70%, straight leg raising while lying was 0-50 and while sitting 0-90. The impression was blood pressure is elevated on exam. As regard chronic neck and back pain the examiner noted to refer to range of motion sheet. The sheet notes all the exam was within normal except for lumbar spine. The physical assessment noted that the Claimant could do all activities with complaints of pain for sitting, standing, bending, stooping carrying, pushing, pulling and squatting and arising from a squat.

A consultative Mental Status Exam was conducted on [redacted] No psychiatric hospitalizations or outpatient treatments noted. The Claimant advised the examiner that he had not had a drink since [redacted]. The diagnosis was adjustment disorder with mixed anxiety and depressed mood. Alcohol use disorder reported (several month) remission, and antisocial personality disorder. The prognosis was fair.

On [redacted] the Claimant was admitted for a drug overdose of Wellbutrin and suicide attempt due to depression. The Claimant was discharged after five days.

The Claimant returned on [redacted] because he reported he could not take the prescribed medications. He could not afford them because he had no insurance. The final impression was back pain and the Claimant was given toradol injection and Depo Medrol injection. The Claimant was also given medication for depression.

The Claimant was seen on [redacted] in the ER and at that time the impression was alcohol abuse follow up. The Claimant had just completed Alcohol Program at Brighton from [redacted]. At the time the Claimant was not drinking. After an examination the Impression was liver disease, chronic, folate deficiency, back pain with spasm, emphysema and tobacco use disorder with follow up with psychiatrist.

On [redacted] the Claimant was seen due to heavily ETOH.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the Claimant has presented objective medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities. Accordingly, the 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, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant has alleged physical disabling impairments which include chronic neck and back pain, COPD, AND hypertension.

The Claimant has alleged mental disabling impairments including depression. The Claimant has not received any outpatient treatment.

The Listings for COPD, 3.02 Chronic Pulmonary Insufficiency; and Depression, 12.04 Affective Disorders; and Listing 1.04, Disorders of the Spine were all consulted. Although the Claimant has COPD the pulmonary function test contained in the Medical

Evidence was rated as mild obstruction and did not meet the FEV of 1.35. The Listing at 3.00 E notes that:

> Impairments caused by chronic disorders of the respiratory system generally produce irreversible loss of pulmonary function due to ventilatory impairments, gas exchange abnormalities, or a combination of both. The most common symptoms attributable to these disorders are dyspnea on exertion, cough, wheezing, sputum production, hemoptysis, and chest pain.

Based upon the review of the medical evidence and even considering the fact that the Claimant does use an inhaler, the listing is not met.

Listing 12.04 was also reviewed and was deemed not met. The Claimant did attempt suicide due to depression in [redacted]. Since that time the Claimant has not received treatment and while a suicide attempt is serious, the Claimant has received no treatment and is on medication which is prescribed by his doctor.

Lastly Listing 1.04 was reviewed and it is determined that although there is evidence of continued cortisone injections in the neck, there was no testing such as MRI evidence of any nerve root impingement; thus, the severity requirements of this listing were not met. Additionally, the Claimant's range of motion during the consult exam was normal, straight leg raising was negative and no muscle spasm was noted. As no Listings were demonstrated as met the Claimant is deemed not disabled or disabled at Step 3 thus a Step 4 analysis is necessary under 20 CFR 416.905(a).

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

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

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of

walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b). Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.* Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

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

sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.*

The Claimant's prior work history consists of employment as a carpenter and a window installer. The work required Claimant to climb ladders and carry tools weighing between 30-50 pounds. The Claimant completed the 10th grade and completed a GED. In light of the Claimant's testimony and records, and in consideration of the Occupational Code, the Claimant's prior work is classified as semi-skilled medium. It is determined that the Claimant can no longer do such work as the Claimant's COPD and neck injections, as well as noted difficulty getting on and off the exam table during the consultative exam, would limit his from doing this type of strenuous work.

The Claimant testified that he is able to walk three blocks, and can sit for 30 minutes and then experiences numbness and pain shooting down his right leg. The Claimant can stand 30 minutes; he can shower and dress himself, and cannot squat. The Claimant can tie his shoes, but cannot touch his toes. The Claimant further noted persistent pain even with pain medication. The Claimant indicated that he can carry 10 pounds. The Claimant is able to grocery shop by leaning on the cart; he does not use a cane, and can do dishes and laundry in shifts having to sit due to being out of breath. He can also climb stairs slowly, with some pain.

If the impairment or combination of impairments does not limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. 20 CFR 416.920. In consideration of the Claimant's testimony, medical records, and current limitations, it is found that the Claimant is not able to return to past relevant work; due in large part the lifting requirements and climbing ladders. Thus, the fifth step in 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). The Claimant is [redacted] years old and, thus, is considered to be a person of advanced age for MA purposes. The Claimant has an 10th grade education and a GED. 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 the Claimant has a medical impairment due to hypertension, chronic neck and back pain. The Claimant is receiving ongoing treatment for his neck pain, including receiving injections and pain medications.

Based upon the foregoing objective medical evidence, particularly the Claimant's primary care doctor who is familiar with his conditions and abilities since August 2014, there is evidence based upon the DHS 49 that the Claimant, notwithstanding his physical impairments, is capable of performing light work as his doctor has evaluated his abilities at that level. Additionally, in light of the Claimant's past history of alcoholism, it is determined that alcohol is not material to the Claimant's current conditions and physical impairments.

This Administrative Law Judge does take into account Claimant's complaints of pain and that the diagnoses do support the claims. Subjective complaints of pain where there are objectively established medical conditions that can reasonably be expected to produce the pain must be taken into account in determining a Claimant's limitations. *Duncan v Secretary of HHS*, 801 F2d 847, 853 (CA6, 1986); 20 CFR 404.1529 416.929.

A review of the Claimant's medical records, reports from Claimant's primary care physician, and Claimant's own testimony, has established limitations which would compromise his ability to perform medium work activities on a regular and continuing basis.

In consideration of the foregoing and in light of the objective limitations, it is found that the Claimant does retain the residual functional capacity for work activities on a regular and continuing basis to meet at the physical and mental demands required to perform light work. In addition, it is determined that his skills as a carpenter and laborer are not transferable. After review of the entire record, the Findings of Fact and Conclusions of Law, and in consideration of the Claimant's age, education, work experience and residual functional capacity, it is found that the Claimant is disabled for purposes of the MA-P program at Step 5 pursuant to Rule 202.02.

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 disabled for purposes of the MA and/or SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE OF MAILING OF THIS DECISION AND ORDER:

1. The Department shall process the Claimant's MA-P application dated April 10, 2014 and retro application to determine whether all non-medical eligibility requirements are met.

2. A review of this case shall be conducted in April 2016.

3. The Department shall provide notice of its eligibility decision to the Claimant and the Claimant's AHR, [redacted].

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **4/3/2015**

Date Mailed: **4/3/2015**

LMF / cl

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]