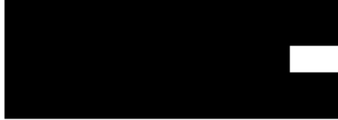
STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:



Reg. No.: 14-017771
Issue No.: 2009
Case No.:
Hearing Date: January 15, 2015
County: Wayne (19)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

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; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 45 CFR 99.1 to 99.33; and 45 CFR 205.10. After due notice, a telephone hearing was held on January 15, 2015, from Detroit, Michigan. Participants included the above-named Claimant. testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Department of Human Services (DHS) included , medical contact worker.

ISSUE

The issue is whether DHS properly denied Claimant's Medical Assistance (MA) eligibility for the reason that Claimant is not a disabled individual.

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 , Claimant applied for MA benefits, including retroactive MA benefits from 3/2014.

2. Claimant's only basis for MA benefits was as a disabled individual.

3. On the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 9-10).

4. On , DHS denied Claimant's application for MA benefits and mailed Benefit Notices (Exhibits 172-174) informing Claimant and Claimant's AHR of the denial.

5. On [redacted] Claimant's AHR requested a hearing disputing the denial of MA benefits.

6. As of the date of the administrative hearing, Claimant was a 48 year old male.

7. Claimant has not earned substantial gainful activity since before the first month of benefits sought.

8. Claimant's highest education year completed was the 12th grade.

9. Claimant has a history of semi-skilled employment, with no known transferrable job skills.

10. Claimant alleged disability based on restrictions related to COPD, memory loss, sleep apnea, dementia, cardiac problems, neck and shoulder pain, dizzy spells, and neuropathy.

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by the Title XIX of the Social Security Act, 42 USC 1396-1396w-5, and is implemented by 42 CFR 400.200 to 1008.59. The Department of Human Services (formerly known as the Family Independence Agency) administers the MA program pursuant to MCL 400.10 and MCL 400.105. Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM) and Department of Human Services Bridges Eligibility Manual (BEM) and Department of Human Services Reference Tables Manual (RFT).

Prior to a substantive analysis of Claimant's hearing request, it should be noted that Claimant's AHR noted special arrangements in order to participate in the hearing; specifically, a 3-way telephone hearing was requested. Claimant's AHR's request was granted and the hearing was conducted accordingly.

The Medicaid program is comprised of several sub-programs which fall under one of two categories; one category is FIP-related and the second category is SSI-related. BEM 105 (10/2010), p. 1. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories. *Id*. It was not disputed that Claimant's only potential category for Medicaid eligibility would be as a disabled individual.

Disability for purposes of MA benefits is established if one of the following circumstances applies:

- by death (for the month of death);
- the applicant receives Supplemental Security Income (SSI) benefits;
- SSI benefits were recently terminated due to financial factors;
- the applicant receives Retirement Survivors and Disability Insurance (RSDI) on the basis of being disabled; or
- RSDI eligibility is established following denial of the MA benefit application (under certain circumstances).
  BEM 260 (7/2012) pp. 1-2

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for Medicaid eligibility without undergoing a medical review process which determines whether Claimant is a disabled individual. *Id.*, p. 2.

Generally, state agencies such as DHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) 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 functionally identical definition of disability is found under DHS regulations. BEM 260 (7/2012), p. 8.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id.*, p. 9. Significant duties are duties used to do a job or run a business. *Id.* They must also have a degree of economic value. *Id.* The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id.*

The person claiming a physical or mental disability has the burden 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 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).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person

is statutorily blind or not. "Current" work activity is interpreted to include all time since the date of application. The 2014 monthly income limit considered SGA for non-blind individuals is $1,070.

Claimant credibly denied performing any employment since the date of the MA application; no evidence was submitted to contradict Claimant's testimony. Based on the presented evidence, it is found that Claimant is not performing SGA and has not performed SGA since the date of MA application. Accordingly, the disability analysis may proceed to step two.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the 12 month duration requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id.*

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon claimants to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirement is intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Claimant's impairments amount to a severe impairment, all other relevant

evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Hospital documents (Exhibits 96-98) dated [redacted] were presented. It was noted that Claimant underwent left heart catheterization and stenting.

A cardiologist letter (Exhibit 62) dated [redacted] was presented. It was noted that Claimant was treated for mild dyspnea and fatigue with exertion. Claimant's ejection fraction was noted to be 44%. An assessment of coronary artery disease was noted.

A radiology report of Claimant's right shoulder (Exhibit 69) dated [redacted] was presented. An impression of mild degenerative changes was noted.

A radiology report of Claimant's cervical spine (Exhibit 70) dated [redacted] was presented. An impression of degenerative changes and C5-C6 disc narrowing was noted.

A cardiologist letter (Exhibits 87-88) dated [redacted] was presented. It was noted that Claimant reported an incident where he could not remember what he was doing. Mild left ventricle dysfunction and an ejection fraction of 45% were noted.

A cardiologist treatment document (Exhibit 99) dated [redacted] was presented. It was noted that Claimant underwent 24 hour Holter monitoring. An impression of rare isolated PVCs and PACs was noted.

Neurologist treatment documents (Exhibits 122-123; A15-A16) dated [redacted] were presented. It was noted that Claimant reported memory loss, ongoing for 3-4 months, concentration difficulty, and word finding difficulty. Syncope episodes involving dizziness and dyspnea were reported. The following observations and findings were noted: normal gait, intact recent and remote memory, and 5/5 muscle strength. Claimant's memory loss was noted to be likely multifactorial due to poor sleep and stress. A plan of a brain MRI was noted.

Neurologist treatment documents (Exhibit 112; A17) dated [redacted] were presented. An impression of central vestibular abnormality was noted.

Neurologist treatment documents (Exhibits A13-A14) dated [redacted] were presented. It was noted that Claimant complained of ongoing dizziness. A CT head and lab workup was noted as pending. An EEG was noted as planned.

A physician office visit document (Exhibit 121; A11-A12) dated [redacted] was presented. It was noted that Claimant reported slightly improved dizziness and no recent falls. Claimant reported ongoing memory loss.

Neurologist treatment documents (Exhibits 78; 111; A27) dated [redacted] were presented. It was noted that an EEG was performed. An impression of a normal EEG (in awake and sleep state) was noted.

A Medical Source Statement- Physical (Exhibits 63-65) dated [redacted] was presented. The statement was completed by a person with unknown credentials. Diagnoses of vertigo, sleep apnea, and osteoarthritis were noted. Claimant's physician noted that Claimant's impairments were verified to have begun 5/2013. A fair prognosis was noted. Impairments were noted to have lasted or be expected to last 12 months or longer. The form's author opined that Claimant was restricted as follows over an eight-hour workday, less than 2 hours of standing and/or walking, and less than 2 hours of sitting. Claimant was found to be restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. It was noted that Claimant had no left hand restrictions but was limited to using his right hand for 30% of an 8 hour workday. It was noted that Claimant was not expected to have work absences because of impairments.

Hospital documents (Exhibits 27-49) from an admission dated [redacted] were presented. It was noted that Claimant presented with complaints of chest pain, ongoing for 1-2 weeks. Chest and abdominal radiology were noted to be negative other than mild degenerative disease in Claimant's lumbar. Physical examination findings were all normal and/or unremarkable.

An echocardiogram report (Exhibits 93-95) dated [redacted] was presented. Claimant's ejection fraction was noted to be 45%. Mild left ventricle dysfunction was noted.

Neurologist treatment documents (Exhibits 76-77; 120; A9-A10) dated [redacted] were presented. It was noted that Claimant presented with complaints of dizziness and memory loss. Claimant's complaints were noted to be possibly caused by poor sleep. A sleep study was noted as pending. It was noted that Claimant reported better sleep after taking Ambien. Dizziness was noted as stable.

Orthopaedic physician office visit documents (Exhibits 135-138) dated [redacted] were presented. It was noted that Claimant presented with complaints of right-sided neck and shoulder pain.

A radiology report of Claimant's cervical spine (Exhibit 139-140) dated [redacted] was presented. An impression of mild-to-moderate degenerative changes was noted.

Orthopaedic physician office visit documents (Exhibits 132-134) dated [redacted] were presented. It was noted that Claimant complained of right shoulder and neck pain. A full range of shoulder and neck motion was noted. It was noted that Claimant's neck had mild tenderness. An injection of Kenalog, Marcaine, and Lidocaine was noted as administered to hopefully relieve tendonitis.

Physician office visit documents (Exhibits 107-108; 142-144) dated ██████ were presented. It was noted that Claimant presented for follow-up of sleep apnea. Assessments of excessive sleepiness, snoring, and OSA were noted.

Neurology treatment documents (Exhibits 109-110) from 5/2014 were presented. It was noted that Claimant underwent ambulatory EEG testing over 4 days (3 nights). Bitemporal slow waves were noted. A clinical impression of focal cerebral dysfunction was noted.

A physician office visit document (Exhibit 119; 125-126; A7-A8) dated ██████ was presented. It was noted that Claimant complained of ongoing memory loss, dizziness, and balance loss. Claimant's memory loss was noted to be likely multifactorial due to poor sleep and stress. A plan of a brain MRI was noted.

An MRI report of Claimant's brain (Exhibit 127; 171) dated █████ was presented. An impression of no acute intracranial process was noted.

A cardiologist letter (Exhibits 91-92) dated █████ was presented. It was noted that Claimant complained of dyspnea, mild dizziness, and jaw pain following exertion. A plan noted the scheduling of a stress test.

A Medical Examination Report (Exhibits 101-102) dated ██████ was presented. The form was completed by a cardiologist with an approximate 4 year history of treating Claimant. Claimant's physician listed diagnoses of jaw pain, COPD, coronary artery disease, dizziness, and dyspnea. An impression was given that Claimant's condition was deteriorating. It was noted that Claimant can meet household needs.

Orthopaedic physician office visit documents (Exhibits 129-131; 156-158) dated ██████ were presented. It was noted that Claimant complained of right shoulder and neck pain. It was noted that a recent shoulder medication injection was not helpful. It was noted that radiology demonstrated marked degeneration of the subaxial cervical spine. An assessment of cervical spondylosis was noted. A plan to continue physical therapy and an MRI of the cervical spine was noted.

Physician office visit documents (Exhibits 154-155; 162-163; A5-A6) dated ██████ were presented. It was noted that Claimant complained of ongoing dizziness. It was noted that Claimant reported that symptoms are sometimes improved by Valium. It was noted that physical therapy did not improve symptoms. A continuing assessment of memory loss was noted.

An MRI report of Claimant's cervical spine (Exhibits 159-160) dated █████ was presented. An impression of facet and uncovertebral changes causing severe right neural foraminal narrowing at C3-C4 and C4-C5 was noted. Moderate narrowing was also noted at C5-C6.

Physician office visit documents (Exhibits 145-147; A20-A31) dated [redacted] were presented. It was noted that Claimant reported ongoing wheezing and dyspnea. Pulmonary function testing was noted to show moderate obstructive lung disease. Claimant's FEV1 was noted to be 55% of predicted. Claimant's FVC was noted to be 55% of predicted. A plan to start Ventolin was noted. A plan to initiate CPAP treatment was noted. It was noted that Claimant was advised to quit smoking.

Neurologist treatment documents (Exhibits A3-A4) from [redacted] were presented. It was noted that Claimant complained of worsening memory loss including incidents of confusion and incontinence. An increase in Aricept dosage was noted. It was noted that incontinence episodes were concerning for epilepsy, however, an EEG from 5/2014 was negative for epilepsy. A plan to continue monitoring was noted.

Neurologist treatment documents (Exhibits A1-A2) from [redacted] were presented. It was noted that Claimant complained of worsening memory loss and ongoing dizziness. Continuing assessments of memory loss and dizziness were noted. A new prescription for Neurontin was noted.

Claimant testified that he has lifting/carrying and ambulation restrictions related to various problems. Presented records primarily verified ongoing treatment for dizziness though no clear physical basis for Claimant's complaints was verified. Treatment for neck and shoulder pain and cardiac treatment was verified. The records were sufficient to verify lifting/carrying and ambulation restrictions.

It is found that Claimant established significant impairment to basic work activities for a period longer than 12 months. Accordingly, it is found that Claimant established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires a determination whether the Claimant'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 Claimant's impairments are listed and deemed to meet the 12 month requirement, then the claimant is deemed disabled. If the impairment is unlisted, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Claimant's complaints of shoulder pain. The listing was rejected due to a failure to establish that Claimant is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on Claimant's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Claimant's complaints of dyspnea. The listing was rejected due to a lack of respiratory test results meeting listing requirements.

A listing for sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

Cardiac-related listings (Listing 4.00) were considered based on Claimant's cardiac treatment history. Claimant failed to meet any cardiac listings.

It is found that Claimant failed to establish meeting a SSA listing. Accordingly, the analysis moves to step four.

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 it is determined that a claimant can perform past relevant work. *Id*.

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 is 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 testified that he held several jobs over the last 15 years. Claimant's past employment includes the following jobs: product assembler, housekeeping, driving a hi-lo, and other various temporary labor jobs. Claimant testified that all of his jobs required standing and lifting which he can no longer perform. Claimant's testimony was consistent with presented medical documents. It is found that Claimant is unable to perform past employment and the analysis may proceed to the final step of the disability analysis.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. 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).

To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967. The definitions for each are listed below.

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 additionally 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 are considered nonexertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the

rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

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.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Claimant's age, education and employment history a determination of disability is dependent on Claimant's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Physician statements of restrictions were provided. Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

A New York Heart Association Classification (Exhibit 100) dated [redacted] from Claimant's treating cardiologist was presented. Claimant's functional capacity was noted to be Class III. A Class III functional capacity is representative of a patient with cardiac disease resulting in marked limitations of physical activity. It is also consistent with someone comfortable at rest while less than ordinary physical activity causes fatigue, palpitation, dyspnea or anginal pain. A Class D therapeutic classification was noted; this is representative of a patient with cardiac disease whose ordinary physical activity should be moderately restricted and whose more strenuous efforts should be discontinued. The restrictions were consistent with a person likely capable of performing sedentary employment, though more strenuous employment would be improbable.

On a Medical Examination Report from 6/2014, Claimant's cardiologist opined that Claimant was restricted to less than 2 hours of standing and/or walking per 8 hour workday. An ejection fraction of 36%, dyspnea, and angina were noted to justify restrictions. The standing restrictions appeared to be justified. It is less certain why Claimant's ability to sit was restricted. The restrictions were consistent with finding that Claimant would be unable to perform any degree of employment.

Claimant's physician restricted Claimant to occasional lifting/carrying of 20 pounds and less, never 25 pounds or more. This restriction is generally consistent with the lifting ability to perform sedentary, and even light employment.

If cardiac problems were Claimant's only problem, Claimant would likely be capable of performing sedentary employment. As it happened, Claimant also has ongoing dizziness, memory loss, dyspnea related to COPD verified by respiratory testing, and

severe neck pain as verified by radiology. It is also concerning that Claimant's health appears to be only deteriorating despite a significant amount of medical treatment.

The combination of Claimant's impairments justifies a finding that Claimant is not capable of performing the standing or lifting required of any employment. It is found that Claimant is a disabled individual. Accordingly, it is found that DHS erred in denying Claimant's MA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that DHS improperly denied Claimant's application for MA benefits. It is ordered that DHS:

(1) reinstate Claimant's MA benefit application dated [redacted], including retroactive MA benefits from 3/2014;
(2) evaluate Claimant's eligibility for benefits subject to the finding that Claimant is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Claimant is found eligible for future benefits.

The actions taken by DHS are **REVERSED**.

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Interim Director
Department of Human Services

Date Signed: **2/12/2015**

Date Mailed: **2/12/2015**

CG / hw

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: