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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-010211
Issue No.: 4009
Case No.: [redacted]
Hearing Date: July 23, 2015
County: Grand Traverse

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 July 23, 2015, from Detroit, Michigan. Participants included the above-named Claimant. Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], specialist, [redacted], PATH coordinator, [redacted], specialist, and [redacted], specialist.

ISSUE

The issue is whether MDHHS properly denied Claimant's State Disability Assistance (SDA) 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 April 7, 2015, Claimant applied for SDA benefits.

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

3. On May 27, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 410-412.

4. On May 28, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action (Exhibits 4-5) informing Claimant of the denial.

5. On June 9, 2015, Claimant requested a hearing disputing the denial of SDA benefits (see Exhibits 2-3).

6. On July 23, 2015, an administrative hearing was held.

7. During the hearing, Claimant and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 10 days to allow Claimant to submit July 2015 medical records from her rheumatologist and cardiologist; an Interim Order Extending the Record was subsequently mailed to both parties.

9. On August 4, 2013, Claimant submitted additional documents (Exhibits B1-B20, C1-C21).

10. As of the date of the administrative hearing, Claimant was a [redacted] old female.

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

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

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

14. Claimant alleged disability based on restrictions related to sleep apnea hypertension (HRN), Raynaud's disease, and scleroderma.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (1/2012), p. 1.A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or

- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS). *Id*.

There was no evidence that any of the above circumstances apply to Claimant. Accordingly, Claimant may not be considered for SDA eligibility without undergoing a medical review process (see BAM 815) which determines whether Claimant is a disabled individual. *Id*., p. 3.

Generally, state agencies such as MDHHS 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. As noted above, SDA eligibility is based on a 90 day period of disability.

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 2015 monthly income limit considered SGA for non-blind individuals is $1,090.

Claimant credibly denied performing any employment since the date of the SDA 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 application. Accordingly, the disability analysis may proceed to Step 2.

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 12 month durational period is applicable to MA benefits; as noted above, SDA eligibility requires only a disability duration of 90 days.

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.

Claimant testified that her left-ring finger is "self-amputating." Claimant testified she is hopeful about keeping her finger and that she has a good prognosis. Claimant testified

that she needs ongoing treatment and has to patiently undergo a healing process for her finger.

A sleep apnea study report (Exhibits 88-90) dated July 9, 2014 was presented. It was noted that Claimant reported symptoms of morning headaches, loud snoring, and excessive daytime sleepiness. It was noted that during the sleep study, Claimant spent more time in apnea than in breathing. Claimant's sleep apnea was described as severe and Claimant was noted to be seen urgently so that treatment could be discussed. A plan of CPAP therapy was noted as the only viable option for Claimant.

Medical center documents (Exhibits 99-166) from an admission dated August 24, 2014 were presented. It was noted that Claimant presented for alcohol detoxification. Claimant reported she binge drank the previous 2 weeks. It was noted that Claimant was homeless. Uncontrolled HTN, depression, and obesity were noted as comorbidities. It was noted that Claimant was given medications for HTN and depression. A discharge date was not apparent though it was noted that Claimant was hospitalized for 5 days.

Medical center documents (Exhibits 167-173) from an admission dated August 29, 2014 were presented. It was noted that Claimant presented for alcohol rehabilitation program treatment. A discharge date of September 14, 2014 was noted.

An Initial Clinical Assessment from a mental health center (Exhibits 71-77) dated September 18, 2014 was presented. Mental status examination observations included the following: unremarkable speech, anxious mood, anxious and flat affect, focused concentration, and fair judgment. An Axis I diagnosis of alcohol dependence was noted. Claimant's GAF was noted to be 60.

Medical center documents (Exhibits 183-254) dated October 23, 2014 were presented. It was noted that Claimant reported her blood pressure was 217/112. Claimant also reported recurring headaches, ongoing for 3 weeks. It was noted that Claimant was admitted for uncontrolled HTN. It was noted that Claimant's headaches were caused by medications, which were subsequently discontinued. It was noted that an EKG showed normal sinus rhythm. It was noted that a CT of Claimant's head showed abnormalities, noted as likely caused by Claimant's alcohol abuse. An impression of mild cardiomegaly was noted following a chest x-ray. It was noted that Claimant's medications were adjusted and that her blood pressure at discharge was 127/70. Discharge medications included Wellbutrin, Losartan, Minoxidil, and BuSpar. A discharge date was not apparent.

Hospital documents (Exhibits 254-279) from an encounter dated November 14, 2014 were presented. It was noted that Claimant presented with complaints of leg swelling, ongoing for more than 3 weeks. It was noted that a chest x-ray was normal. It was noted that an EKG showed normal sinus rhythm. Claimant was discharged and advised to take Lasix.

Hospital documents (Exhibits 280-379) from an encounter dated February 5, 2014 were presented. It was noted that Claimant was admitted after stating, while intoxicated, that she wished to suffocate herself. A history suggestive of PTSD and bipolar disorder was noted. It was noted that Claimant participated with group therapy. A history of previous substance abuse treatments was noted. Various medications were administered throughout Claimant's hospitalization. A discharge date of February 13, 2015 was noted.

Mental health clinic visit notes (Exhibits 42-43; 60-66) dated February 17, 2015 were presented. A goal of managing depression and anxiety was noted. It was noted that Claimant would receive the following services: medication reviews, self-help group sessions, registered nurse services, and targeted case management.

Sleep disorder center documents (Exhibits 380-386) dated February 23, 2015 were presented. It was noted that a download of Claimant's APAP device demonstrated excellent adherence to therapy. A diagnosis of severe obstructive sleep apnea was noted. Claimant was noted as "doing very well" on CPAP.

Mental health clinic psychiatric notes (Exhibit 67-70) dated March 9, 2015 were presented. It was noted that Claimant reported a history of depression and alcohol abuse since her 20s. Claimant reported that he recent suicidal ideation was a cry for help. Axis I diagnoses of severe alcohol use disorder and persistent depression disorder were noted. Claimant's GAF was 60. It was noted that Abilify may have caused Claimant's restlessness; a plan to discontinue Abilify was noted.

Nurse practitioner office visit notes (Exhibits 24-26) dated March 11, 2015 were presented. It was noted that Claimant reported left-hand ring finger pain. Assessment of cellulitis and obesity were noted; Claimant was prescribed Doxycycline for her finger. Prescriptions for Gabapentin and Hydroxyzine, Ibuprofen, Lidocaine, Hydro-chlorothiazide, and Coreg were also noted.

Mental health clinic physician visit notes (Exhibit 39) dated March 23, 2015 were presented. It was noted that Claimant reported feeling better after being weaned off of Abilify. Claimant reported difficulty with sleep due to pain. An increase in Gabapentin dosage was noted.

Mental health clinic office visit notes (Exhibits 28-31; 387-406) dated March 23, 2015 were presented. It was noted that Claimant reported that her left-hand ring finger was getting darker and that pain persisted. Claimant also reported that her blood pressure was consistently around 150/80. A diagnosis of a small area of necrosis was observed on Claimant's distal left ring finger. It was noted that Claimant's nail was starting to fall-off. Assessments of HTN and Raynaud's syndrome were noted. Claimant was advised to see a specialist for her finger.

Various mental health clinic visit notes (Exhibits 49-59) from March 2015 and April 2015 were presented. It was noted that Claimant planned to concentrate on decreasing depression and anxiety attacks.

Mental health clinic physician visit notes (Exhibits 40-41) dated April 8, 2015 were presented. It was noted that Claimant reported fewer anxiety and fewer alcohol cravings. An assessment of alcohol use disorder (severe and persistent) was noted. A trial of trazadone was prescribed in response to a complaint of restless sleep.

A radiology report of Claimant's left 4th finger (Exhibits 408-409) dated April 17, 2015 was presented. An impression of normal hands was noted.

Nurse practitioner office visit notes (Exhibits 32-35; A3-A5) dated April 20, 2015 were presented. Ongoing problems of HTN and Raynaud's syndrome were noted. Some other active problems included a body-mass-index exceeding 40, alcohol abuse, tobacco abuse, anxiety and depression, lower extremity edema, and sleep apnea.

A Medical Examination Report (Exhibits 414-416) dated May 28, 2015 was presented. The form was completed by a rheumatologist with an approximate 1 month history of treating Claimant. Claimant's physician listed diagnoses of limited scleroderma and Raynaud's disease with gangrene. An impression was given that Claimant's condition was stable. It was noted that Claimant can meet household needs.

Nurse practitioner office visit notes (Exhibits 421-424; A9-A20) dated May 6, 2015 were presented. It was noted that Claimant presented with a necrotic ulcer on her left ring finger. A prescription for sildenafil was noted.

Nurse practitioner office visit notes (Exhibits 417-420) dated May 28, 2015 were presented. It was noted that Claimant reported less pain and Raynaud's episodes while taking sildenafil. Claimant was encouraged to minimize smoking and to continue with sildenafil.

Vascular center office visit notes (Exhibits A6-A8) dated June 23, 2015 were presented. It was noted that Claimant presented with a left-hand 4th finger ulcer. An assessment of severe Raynaud's phenomena was noted.

Mental health center psychiatrist office visit notes (Exhibits A1-A2) dated June 30, 2015 were presented. It was noted that Claimant reported feeling more depressed after taking a trial of Lexapro. Claimant's gait was noted as steady. An assessment of periodic anxiety responding well to Gabapentin was noted. A plan to double Gapapentin dosages was noted.

Physician office visit notes (Exhibits B1-B5) dated July 31, 2015 were presented. It was noted that Claimant's HTN was well controlled following a change in medication.

Physician office visit notes (Exhibits B6-B9) dated July 24, 2015 were presented. It was noted that Claimant presented for treatment of 4th finger gangrene. It was noted that Claimant's finger appeared stable and that surgery was not a current option. A plan to continue Sildenafil was noted. It was noted that Claimant would see a cardiologist for a complaint of leg edema.

Claimant alleged various symptoms involving depression and anxiety. Claimant testified that her mental status is improving because of effective medication.

Claimant testified that she can only walk "a few blocks" before lower back pain prevents further ambulation. Presented documents failed to note any complaint, diagnosis or treatment for back pain. Presented records did not suggest any ambulation or standing restrictions. Without proof of ambulation restrictions or diagnoses suggestive of ambulation restrictions, a severe impairment will not be inferred.

Claimant testified that she wears latex glove in the shower because chemicals (e.g. shampoo or soap) cause pain. Claimant testified that she also has to wear a latex glove for cleaning and laundry. Claimant testified that she cannot be in the cold because it pains her hands. Claimant testified that her toes have not been affected by the scleroderma or Raynaud's though she says she has an ingrown toenail.

Presented documents verified ongoing treatment for scleroderma since April 2015. The diagnosis and gangrene on claimant's left-ring finger are sufficient to infer lifting/carrying restrictions.

It is found that Claimant established significant impairment to basic work activities for a period longer than 90 days. 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.

Claimant's most prominent impairment appears to be scleroderma related to Raynaud's disease. The relevant listing reads as follows:

a. ***Systemic sclerosis (scleroderma)*** As described in 14.00D3. With:
C. Raynaud's phenomenon, characterized by:
1. Gangrene involving at least two extremities; or
2. Ischemia with ulcerations of toes or fingers, resulting in the inability to ambulate effectively or to perform fine and gross movements effectively as defined in 14.00C6 and 14.00C7;

Presented evidence verified that Claimant has gangrene at the tip of her non-dominant hand ring finger. A second affected extremity was not alleged. The evidence was not indicative that Claimant is unable to ambulate ineffectively.

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.

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

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 she last worked full-time in the summer of 2014 as a seasonal food preparer. Claimant testified that her job was to wash and cut produce for it to be flash frozen. Claimant testified she was able to wear latex gloves to protect herself from the cold. Claimant testified that her Raynaud's and auto-immune symptoms have progressed since then and would her from currently performing the employment.

Claimant testified that she was a free-lance print graphic designer as of 2002. Claimant testified that she is out-of-date in her technology. Claimant testified that she has difficulty using computers. Claimant conceded that she can draw, write, and type with her right hand which is not affected by Raynaud's. Claimant says typing would be difficult and make her an uncompetitive candidate.

Claimant testified that she had various jobs as a cashier for various stores. Claimant testified that she could not perform the employment competitively. Claimant also testified that she cannot repetitively pick up heavy objects.

Claimant's testimony that she would have difficulties performing past employment was credible and consistent with physician-imposed restrictions. It is found that Claimant is unable to perform past employment. Accordingly, the analysis may proceed to the fifth and final step.

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 light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

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.*

Claimant's rheumatologist stated that Claimant had various restrictions as of May 28, 2015. Restrictions were noted to be expected to last longer than 90 days. Claimant was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Claimant's physician opined that Claimant was restricted from performing the following repetitive actions with her left hand: simple grasping, reaching, pushing/pulling, and fine manipulation. Claimant's rheumatologist stated that Claimant's left finger gangrene justified the stated restrictions. The restrictions were consistent with presented evidence.

A lifting/carrying restriction of 10 pounds or less is deemed to significantly impact Claimant's light employment availability. It is possible that Claimant still has ample employment opportunities despite the restriction. It is MDHHS' burden to present evidence of a client's employment opportunities when a client is unable to perform a full range of an exertional type of employment. MDHHS failed to evidence of available light employment that does not require more than 10 pounds of lifting/carrying.

A similar analysis is appropriate for potentially transferrable skills. Claimant's experience as a free-lance graphic designer might have provided Claimant with skills that can be applied to other jobs. The burden of establishing such skills falls on MDHHS. MDHHS did not provide evidence of such skills.

In lieu of evidence of transferrable skills and/or employment opportunities within Claimant's abilities, it must be found that Claimant is unable to perform light employment. For purposes of this decision, it will be found that Claimant can perform a wide-range of sedentary employment.

Based on Claimant's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled employment), employment history (semi-skilled with no known transferrable skills), Medical-Vocational Rule 201.14 is found to apply. This rule dictates a finding that Claimant is disabled. Accordingly, it is found that MDHHS improperly found Claimant to be not disabled for purposes of SDA benefits.

DECISION AND ORDER

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

(1) reinstate Claimant's SDA benefit application dated April 7, 2015;
(2) evaluate Claimant's eligibility 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 MDHHS are **REVERSED**.

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

Date Signed: **8/7/2015**

Date Mailed: **8/7/2015**

CG/tm

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]