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

IN THE MATTER OF:

[redacted]	Reg. No.:	15-010962
[redacted]	Issue No.:	4009
[redacted]	Case No.:	[redacted]
	Hearing Date:	August 10, 2015
	County:	Macomb (12)

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 August 10, 2015, from Detroit, Michigan. Participants included the above-named Claimant. [redacted], Claimant's sister, testified and appeared as Claimant's authorized hearing representative (AHR). Participants on behalf of the Michigan Department of Health and Human Services (MDHHS) included [redacted], hearings facilitator.

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 June 22, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual.

4. On June 23, 2015, MDHHS denied Claimant's application for SDA benefits and mailed a Notice of Case Action informing Claimant of the denial.

5. On July 8, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 51-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 unskilled employment, with no transferrable job skills.

10. Claimant alleged disability based on restrictions related to diagnoses of hemochromatosis, back pain, and various mental health impairments.

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 pre█ented medical documentation. It should be noted that MDHHS inexplicably numbered their packet in reverse order (i.e. high-to-low number from top-to bottom); MDHHS-presented exhibits will be cited accordingly.

An undated and unsigned letter (Exhibit 51) from an unknown person with an unknown relation to Claimant was presented. The letter was not considered due to a lack of authenticity and its hearsay nature.

Hospital documents (Exhibits 58-50; A1-A99) from an admission dated September 26, 2014, were presented. It was noted that Claimant was brought by his family after Claimant displayed altered mental status. It was noted that Claimant had been estranged from his family for the previous 4 years. Claimant's family expressed concern after Claimant was found to be living in deplorable living conditions. Ongoing problems of short-term memory loss and gait disturbance were noted as reported. It was noted that Claimant had a high ETOH level at admission. Two concussions from the past year were noted as reported by Claimant. Claimant's history was deemed suspicious for late-

set schizophrenia vs. early-onset dementia vs. Wernicke's. Physical examination notes dated September 28, 2014, indicated that Claimant had a full range of motion and a normal gait. It was noted that Claimant was cleared for discharge on September 28, 2014, after a period of detoxification. Claimant's discharge was delayed after Claimant heard a popping noise which was later diagnosed as inguinal hernia. It was noted that brain radiology indicated numerous scattered bilateral cerebral white matter foci; assessments of ETOH abuse and possible demyelinating disease vs. lyme vs. ischemic changes vs. other disease was noted. Recommendations of alcohol abuse treatment, psychiatric treatment, and neurologist follow-up were noted. It was noted that blood testing revealed elevated iron levels. A diagnosis of hemochromatosis was noted. A past medical history for alcohol abuse, dementia, delirium, tremens, and hypomagnesium was noted. On October 3, 2014, it was noted that Claimant required use of a walker. It was noted that Claimant reported left shoulder pain; an impression of decreased mineralization was noted following radiology. An impression of increased liver echogenicity, compatible with fatty liver disease was noted following an ultrasound. A discharge date of October 7, 2014, was noted. It was noted that Claimant was discharged to a nursing home due to ongoing hernia problems. A plan of hernia surgery was noted.

An Initial Intake (Exhibits 44-22) (Exhibits 44-22) dated November 21, 2014, was presented. The documents were signed by a social worker from a newly treating mental health agency. It was noted that Claimant recently stayed in a nursing home after hernia surgery. It was noted that Claimant was evicted from the nursing home after he made disparaging remarks about the nursing home to the State of Michigan. It was noted that Claimant lived with his father for his entire life, including after the recent passing of his father. It was noted that Claimant's home was in deplorable and unlivable condition when Claimant last lived in the home; Claimant was noted to be currently homeless. It was noted that Claimant repeatedly mentioned others breaking promises to him. Mental status examination assessments of Claimant included the following: loud communication, tangential and obsessive thought process, anxious mood, good judgment, and good impulse control. An Axis I diagnosis of anxiety disorder was noted. Claimant's GAF was noted to be 45.

Mental health agency treatment documents (Exhibits 21-13) dated December 1, 2014, were presented. A plan of bimonthly therapy visits was noted. A plan of psychiatrist visits every 6-8 weeks was noted.

A Psychiatric Evaluation from a mental health treatment agency (Exhibits 49-45) dated January 22, 2015, was presented. It was noted that Claimant sought treatment for anxiety and poor memory. It was noted that Claimant was a poor historian. It was noted that Claimant was easily distracted and forgetful. It was noted that Claimant reported drinking the past 5 years though Claimant denied drinking since being hospitalized in September 2014. Mental status examination assessments included the following: cooperative attitude, dysphoric mood, constricted affect, tangential and ruminative thought process with flight of ideas, impaired attention, verbose speech, adequate

impulse control, and orientation x3. An Axis I diagnosis of anxiety disorder was noted. Claimant's GAF was noted to be 48.

Mental health agency treatment documents (Exhibits 12-6) dated April 3, 2015, were presented. A plan of bimonthly therapy visits was noted. It was noted that Claimant expressed needing help in obtaining prescriptions.

A Medication Log Summary (Exhibit 50) dated April 27, 2015, was presented. The summary appeared to come from a mental health treatment agency. Current medications included Strattera and Trazadone.

An internal medicine examination report (Exhibits 78-71) dated May 20, 2015, was presented. The report was noted as completed by a consultative physician. Claimant reported complaints of neck pain, foot pain and numbness, hand pain and numbness, photosensitivity, poor memory, jumpy vision, and hemochromatosis. It was noted that Claimant used a walker. It was noted that Claimant's right grip was weaker than his left. Unsteady toe walking, tiptoe walking, and heel walking was noted. Decreased cervical spine, bilateral shoulder, and lumbar spine range of motions was noted. An impression of hemochromatosis, cognitive impairment, peripheral neuropathy, and right inguinal hernia pain was noted. A need for a walking-assistance device was noted.

Claimant testified that "stuff jumps around on me." Claimant's testimony was not clarified. Presumably, Claimant's testimony referred to a vision problem (jumpy vision was a complaint made to a consultative examiner). Vision treatment was not presented. Claimant testified that he can drive short distances. Presented evidence was insufficient to establish any vision problems.

Presented records verified a diagnosis of hemochromatosis. Hemochromatosis is understood to be a hereditary disorder causing excess iron within a person's bloodstream. Symptoms of the disease include fatigue and joint pain. Claimant testified one of his treatments was weekly blood removal; this went on for 5 months. Claimant testified that he currently undergoes blood removal approximately every 1-½ months. Claimant testified that he does not take medication for hemochromatosis. Other physician advice he was given was to avoid foods high in iron. Claimant testified that he has iron deposits on his liver. Claimant testified that the illness adversely affects his memory, heart function, joints, and balance. Claimant testified that he has fallen twice in the recent past. Presented evidence was sufficient to establish some degree of balance, joint pain, and memory difficulties due to hemochromatosis.

Claimant also alleged disability based on impairments related to anxiety disorder and back pain. Presented records verified ambulation, concentration, and memory restrictions which were consistent with Claimant's treatment history.

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 alleged disability, in part, based on anxiety disorder. Anxiety disorders are covered by Listing 12.06, which reads as follows:

> **12.06 *Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.
>
> The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
>   a. Motor tension; or
>   b. Autonomic hyperactivity; or
>   c. Apprehensive expectation; or
>   d. Vigilance and scanning; or
> 2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
> 3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
> 4. Recurrent obsessions or compulsions which are a source of marked distress; or
> 5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;
>
> AND
>
> B. Resulting in at least two of the following:
> 1. Marked restriction of activities of daily living; or
> 2. Marked difficulties in maintaining social functioning; or
> 3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

OR

C. Resulting in complete inability to function independently outside the area of one's home.

The only established mental illness was anxiety disorder. Presented documents were very mixed in establishing a psychological impairment related to anxiety disorder.

A hospitalization related to mental illness was verified. Records indicated that Claimant was drunk at admission and would have been released dafter 1-2 days had he not injured himself during his stay. Speculative but severe diagnosis of dementia and demyelinating disease were indicated following radiology, however, a certain disease was not stated. Follow-up treatment with a neurologist was surprisingly not verified.

A GAF indicative of marked restrictions was verified. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).” It is problematic for Claimant that he appeared to not pursue medications prescribed to him after low GAFs were indicated. It is also problematic for Claimant that his psychological difficulties appear very close in time to a period of 5 year alcohol abuse and very little treatment occurred in the subsequent months (5 appointments in 6 months) of his alleged sobriety. Overall, Claimant’s mental health treatment history was too inconsistent to establish marked restrictions due to anxiety.

A listing for joint dysfunction (Listing 1.02) was considered based on Claimant’s complaints of pain, including shoulder pain. The listing was rejected due to a failure to establish that Claimant is unable to ambulate effectively or perform fine and gross movements effectively.

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

A listing for visual acuity (Listing 2.02) was considered based on complaints of poor eyesight. This listing was rejected due to an absence of vision testing.

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 testimony suggested that he has not worked full-time in approximately the last 10 years. Claimant testified that he worked for his now deceased father in a family business during that period, though the employment was not full-time.

Claimant testified that he worked full-time as a nursing home aide. Claimant testimony indicated that he could not perform the physically demanding duties of this former employment.

Claimant testified that he also previously worked as a driver for a printing company. Presented evidence suggested that Claimant no longer had the mental capacity of full-time driving employment.

It is found that Claimant could not perform past relevant employment form the past 15 years. 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 Claimant restrictions were not presented. Restrictions can be inferred based on presented documents.

Claimant testified he uses a cane for most of his ambulation. A consultative examiner noted that Claimant had sufficient need for a cane. The consultative examiner also verified many restricted ranges of motion. The examiner noted an impression that Claimant had spinal pain, hernia, and hemochromatosis; hemochromatosis and hernia were also verified by a previous hospital admission. This evidence is supportive in finding that Claimant cannot perform light employment.

Treatment for back pain, hernia, and hemochromatosis was not provided. Spinal radiology was not presented. Claimant testified that he had health insurance but was unable to find a physician; Claimant's excuse was not compelling. An absence of treatment and radiology is supportive in finding that Claimant can perform light employment.

Psychiatric treatment documents suggested that Claimant had fairly severe psychological symptoms. Claimant was noted to be a genuinely poor historian when detailing his history. Claimant's low GAF scores were also indicative of poor functioning.

Overall, presented evidence of restrictions was less than ideal. The evidence was sufficient to infer that Claimant's ambulation difficulties would prevent the performance of light employment. Even if Claimant could perform some light employment, Claimant's psychological restrictions would erode Claimant's light employment base to the point that the performance of any light employment would be improbable.

Based on Claimant's exertional work level (sedentary), age (approaching advanced age), education (high school with no direct entry into skilled employment), employment history (unskilled), 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.

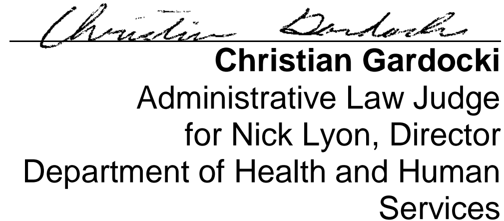
DECISION AND ORDER

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: **8/19/2015**

Date Mailed: **8/20/2015**

GC/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: