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

IN THE MATTER OF:

Reg. No.:	15-002750
Issue No.:	4009
Case No.:	
Hearing Date:	April 22, 2015
County:	Macomb-District 12

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

HEARING DECISION

Following Claimant's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on April 22, 2015, from Detroit, Michigan. Participants on behalf of Claimant included Claimant. Participants on behalf of the Department of Health and Human Services (Department) included , Hearing Facilitator.

During the hearing, Claimant waived the time period for the issuance of this decision in order to allow for the submission of additional records. The record closed on May 22, 2015, and this matter is now before the undersigned for a final determination.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On November 26, 2014, Claimant submitted an application for public assistance seeking SDA benefits.

2. On February 9, 2015, the Medical Review Team (MRT) found Claimant not disabled.

3. On February 19, 2015, the Department sent Claimant a Health Care Coverage Determination Notice denying the application based on MRT's finding of no disability.

4. On March 4, 2015, the Department received Claimant's timely written request for hearing.

5. Claimant alleged physical disabling impairment due to degenerative disc disease, right hip contusion, concussion, vertigo, and head injury.

6. On the date of the hearing, Claimant was ██ years old with a ██████████, birth date; he is ███ in height and weighs about ███ pounds.

7. Claimant graduated from high school and has some college classes.

8. Claimant has an employment history of work as ██████ technician and cook.

9. Claimant's impairments have lasted, or are expected to last, continuously for a period of 90 days or longer.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

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

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

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

> (1) whether the individual is engaged in substantial gainful activity (SGA);
> (2) whether the individual's impairment is severe;
> (3) whether the impairment and its duration meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404;

(4) whether the individual has the residual functional capacity to perform past relevant work; and
(5) whether the individual has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945.

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One
As outlined above, the first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Claimant has not engaged in SGA activity during the period for which assistance might be available. Therefore, Claimant is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two
Under Step 2, the severity of an individual's alleged impairment(s) is considered. If the individual does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs. 20 CFR 416.921(b). Examples include (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b).

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimus* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985).

In the present case, Claimant alleges physical disabling impairment due to degenerative disc disease, right hip contusion, concussion, vertigo, and head injury. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

An October 15, 2013, MRI of the Claimant's cervical spine showed no evidence of disc herniation, no evidence of stenosis, and patent spinal canal and neural foramina (Exhibit A, pp 159-160). On November 6, 2013, Claimant's doctor at [redacted] prescribed a back brace, physical therapy and medication. The doctor's letter noted that with the brace, Claimant experienced a 10% reduction in pain. (Exhibit A, pp. 151-156).

A December 3, 2013, MRI of the lumbar spine showed no acute fracture, facet hypertrophic changes, mild bilateral foraminal narrowing at L5-S1; incompletely evaluated disc desiccation, disc space narrowing and disc herniation at T11-T12 incompletely evaluated in the lower thoracic spine (Exhibit A, pp. 148, 164).

An April 24, 2014, MRI of the thoracic spine showed that the thoracic vertebra were normal in signal, height and alignment and there was no fracture or pathologic marrow signal. The thoracic spinal cord appeared normal in signal and configuration with no evidence for syrinx, mass or other cord signal abnormality. There was a bulging disc at T6-T7, a herniated disc with cord impingement at T7-T8, herniated disc at T8-T9, herniated disc at T9-T10, and bulging disc with mild right-sided foraminal stenosis at T10-11. (Exhibit A, pp. 15-16, 87-88, 91-94, 161-162.)

A July 22, 2014, EMG concluded “irritability bilateral L5-S1 (R>L) suggesting radiculopathy but not definitive. Clinical correlation required.” It also found no evidence of peripheral neuropathy or plexopathy. (Exhibit A, pp. 64-65.) A November 7, 2014 MRI of the lumbar spine showed mild disc bulge at L4-L5, no stenosis (Exhibit A, pp. 21, 163).

Notes from [redacted] show ongoing visits by Claimant regarding his neck and back pain (Exhibit A, pp. 19-20, 22). There are also multiple procedure notes from [redacted] showing that Claimant received lumbar facet rhizotomy with biplanar fluoroscopy on October 23, 2014; October 14, 2014; September 30, 2014; January 8, 2013; and December 31, 2013; transforaminal selective nerve root block under biplanar fluoroscopy on September 5, 2014, and August 18, 2014; thoracic epidural steroid injection under biplanar fluoroscopy on June 23, 2014; May 23, 2014; and May 9, 2014; caudal epidural steroid injection with epidurogram on March 31, 2014; March 13, 2014; and February 13, 2014; and lumbar facet medial branch nerve block under biplanar fluoroscopy on December 24, 2013, and December 18, 2013. (Exhibit A, pp. 23-60, 67-150).

Claimant also participated in physical therapy from June 11, 2014, to July 28, 2014, to address his significant pain from his neck down his spine, his decreased range of motion and strength, and his difficulty sitting, standing, walking and changing positions. Claimant was described as motivated but his progress and tolerance to treatment were fair, and he was discharged due to limited progress and symptoms intensifying. (Exhibit E.)

On February 4, 2015, Claimant participated in a consultative physical examination. In her medical report, the doctor indicated that Claimant reported a history of motor vehicle accident and subsequent diagnosis of spinal stenosis in the thoracic spine, sciatica, hip contusion, head injury with minor loss of consciousness, vertigo, and a bulging disc. He reported chronic pain aggravated by standing, stooping, squatting, lifting, bending, pushing, pulling, reaching, and climbing stairs and pain in his shoulders, hips, arms, knees, wrists and ankles. He also reported mood swings, crying spells, sadness, suicidal thoughts with one suicide attempt, and being hospitalized in 2011 for 14 days due to his mental condition.

In her physical examination of Claimant, the consulting doctor noted tenderness to palpitation in the lower lumbar area but no obvious spinal deformity, swelling or muscle spasm. The doctor noted that Claimant came in with a cane and wore a back brace and knee brace. The doctor indicated that Claimant did not use his cane during the examination but that he used it for balance and support and that it was needed to reduce pain. The doctor concluded that Claimant suffered from chronic spine pain in the cervical, thoracic and lumbar spine due to a motor vehicle accident as well as multiple head injuries. She noted that Claimant suffered from spinal stenosis as well as herniated and bulging discs. She found that his range of motion was normal except that his lumbar spine flexion was 70 (normal is 90), his forward hip flexion was 50 on both

hips (normal is 100), his straight leg raise in the supine position was 50 and his straight leg raise in the seated position was 90. He could slowly walk on heels and toes and in tandem and his gait was compensated and slow. The doctor also noted a history of vertigo and multiple head injuries and that he has been followed by a neurologist. She concluded that Claimant suffered from depression and was taking medication and being followed by a mental health specialist. She indicated that Claimant had no limitations on his abilities and his reflexes were normal. (Exhibit A, pp. 5-12.)

On May 8, 2015, Claimant's neurologist completed a medical exam report, DHS-49, indicating that Claimant suffered from vertigo, post-traumatic head, back and neck pain following a motor vehicle accident, and nausea. The doctor noted that Claimant had difficulty moving, he was fatigued and in chronic pain, he suffered from headaches and bulging discs, and he used a cane. The doctor described Claimant's condition as deteriorating and identified the following limitations: (i) Claimant could lift less than 10 pounds frequently, 10 pounds occasionally, and never 20 pounds or more, (ii) Claimant could sit about 6 hours in an 8 hour day, (iii) he needed a cane for ambulation, and (iv) he could stand or walk for about 2 hours in an 8-hour day. The doctor also indicated that Claimant had limitations in his sustained concentration. (Exhibit D.)

In consideration of the de minimus standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Claimant suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Claimant has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented, Listings 1.00 (musculoskeletal system), particularly 1.02 (major dysfunction of a joint) and 1.04 (disorders of the spine); 2.00 (special senses and speech), particularly 2.07 (disturbance of labyrinthine-vestibular function); and 11.00 (neurological) were reviewed. Claimant's medical record in this case is not sufficient to support a finding that his impairments meet, or equal the severity of, any of the reviewed listings. Because Claimant's impairments are insufficient to meet, or to equal, the severity of a listing, Claimant is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Step 4, the individual's residual functional capacity (RFC) is

assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. Impairments, and any related symptoms, may cause physical and mental limitations that affect what a person can do in a work setting. 20 CFR 416.945(a)(1). RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s) and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4). The RFC takes into consideration the total limiting effects of all impairments, including those that are not severe. 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If the limitations and restrictions imposed by the individual's impairment(s) and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). To determine the exertional requirements, or physical demands, of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a).

> Sedentary work.
> Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
>
> Light work.
> Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, [an individual] must have the ability to do substantially all of these activities. If someone can do light work, . . . he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

> Medium work.
> Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, . . . he or she can also do sedentary and light work.
>
> Heavy work.
> Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, . . . he or she can also do medium, light, and sedentary work.
>
> Very heavy work.
> Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, . . . he or she can also do heavy, medium, light, and sedentary work. 20 CFR 416.967.

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Claimant alleges exertional limitations due to his medical condition. He testified that, because of his neck and back pain and dizziness, he walked with a cane and used a back brace. He could sit for periods of 10 minutes before having to stand and stretch but could not stand for longer than 10 minutes. The hearing facilitator at the hearing confirmed that Claimant was in visible pain during the hearing, that he had stood and stretched during the hearing, and that he used a cane and back brace. Claimant testified that he lived with a roommate and depended on his roommate or father to assist with chores, including shopping.

Claimant's medical records show mild bilateral foraminal narrowing at L5-S1 and disc space narrowing and disc herniation at T11-T12. An April 24, 2014, MRI of his thoracic spine showed normal signal, height and alignment of the thoracic vertebra but bulging discs at T6-T7, herniated disc with cord impingement at T7-T8, herniated discs at T8-T9 and T9-T10, and bulging disc with mild-right-sided foraminal stenosis at T10-T11. (Exhibit A, pp. 15-16, 87-88, 91-94, 148, 159-160, 161-162, 164). In the February 4, 2015, consultative physical exam report, the consulting doctor did not find any limitations in Claimant's current abilities she did note lumbar spine flexion was limited to 70 (normal is 90), his forward hip flexion was limited to 50 on both hips (normal is 100), and his straight leg raise in the supine position was 50 and his straight leg raise in the seated position was 90. The consulting doctor noted that Claimant could slowly walk on heels and toes and in tandem and his gait was compensated and slow. The doctor also

noted a history of vertigo and multiple head injuries and noted that he has been followed by a neurologist. (Exhibit A, pp. 5-12.) The May 8, 2015, medical exam report, DHS-49, completed by Claimant's neurologist noted that Claimant had difficulty moving, he was fatigued and in chronic pain, he suffered from headaches and bulging discs, and he used a cane. The doctor described Claimant's condition as deteriorating and identified the following limitations: (i) Claimant could lift less than 10 pounds frequently, up to 10 pounds occasionally, and never 20 pounds or more, (ii) Claimant could sit about 6 hours in an 8 hour day, (iii) he needed a cane for ambulation, and (iv) he could stand or walk for less than 2 hours in an 8-hour day. (Exhibit D.)

The medical record is sufficient to support Claimant's testimony concerning his pain and limitations. With respect to Claimant's exertional limitations, a review of the entire record and Claimant's testimony, it is found that Claimant maintains the physical capacity to perform, at best, sedentary work as defined by 20 CFR 416.967(a).

Although the February 4, 2015, consultative report also indicates that Claimant reported a psychiatric history for depression, including a 2011 fourteen day hospital admission, at the hearing, Claimant denied suffering from depression or any other mental conditions. He did, however, testify that he suffered from ongoing headaches and vision issues. Claimant's neurologist noted that Claimant suffered from headaches and identified limitations in Claimant's sustained concentration (Exhibit D). An individual's limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, coworkers, and work pressures in a work setting, may reduce his or her ability to do past work and other work. 20 CFR 416.945(c). Based on the evidence presented, Claimant has mild mental impairments which would limit his ability to perform basic work activities.

Claimant's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Claimant's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id.*; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

As determined in the RFC analysis above, Claimant is limited to no more than sedentary work activities and has mild limitations on his mental abilities to perform basic work activities. Claimant's work history in the 15 years prior to the application consists of work as a technician installing ████ (heavy, semi-skilled) and cook (heavy, semi-

skilled). In light of the entire record and Claimant's RFC, it is found that Claimant is unable to perform past relevant work. Accordingly, Claimant cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

In Step 5, an assessment of Claimant's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work.

At this point in the analysis, the burden shifts from Claimant to the Department to present proof that Claimant has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). However, 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). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, at the time of hearing, Claimant was ██ years old and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. He is a high school graduate, with some college classes, and a history of involving semi-skilled work experience. As discussed above, Claimant maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform, at best, sedentary work activities. While the Medical-Vocational Guidelines do not result in a disability finding based on Claimant's exertional limitations, Claimant's medical record also shows nonexertional limitations resulting in mild restrictions in his ability to perform basic work activities. At the hearing, Claimant was clearly in pain and his pain would affect his mental ability to maintain work activities. After review of the entire record, including Claimant's testimony, and in consideration of Claimant's age, education, work experience, physical as well as mental RFC, Claimant is found disabled at Step 5 for purposes of SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Claimant disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is REVERSED.

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

1. Process Claimant's November 26, 2014, SDA application to determine if all the other non-medical criteria are satisfied and notify Claimant of its determination;

2. Supplement Claimant for lost benefits, if any, that Claimant was entitled to receive if otherwise eligible and qualified;

3. Review Claimant's continued eligibility in November 2015.

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **5/29/2015**

Date Mailed: **5/29/2015**

ACE / tlf

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date.

A party may request a rehearing or reconsideration of this Hearing Decision from the Michigan Administrative Hearing System (MAHS) within 30 days of the mailing date of this Hearing Decision, or MAHS may order a rehearing or reconsideration on its own motion.

MAHS may grant a party's Request for Rehearing or Reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision;
- Misapplication of manual policy or law in the hearing decision which led to a wrong conclusion;
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client;
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The party requesting a rehearing or reconsideration must specify all reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration. A request must be *received* in MAHS within 30 days of the date this Hearing Decision is mailed.

A written request may be faxed or mailed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088 and be labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

cc: