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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-003861
Issue No.: 4009
Case No.: [redacted]
Hearing Date: July 9, 2015
County: Wayne (15)

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 9, 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], medical contact worker.

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 January 5, 2015, Claimant applied for SDA benefits.

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

3. On February 12, 2015, the Medical Review Team (MRT) determined that Claimant was not a disabled individual (see Exhibits 1-3).

4. On February 19, 2015, MDHHS denied Claimant's application for SDA benefits and mailed an Application Eligibility Notice informing Claimant of the denial.

5. On March 3, 2015, Claimant requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Claimant was a 50 year old female.

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

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

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

10. Claimant alleged disability based on restrictions related to a stroke.

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.

A Long-Term Disability Residual Functional Capacity for Psychiatric Impairment (Exhibits 57-59) from February 2011 was presented. Diagnoses of major depression (recurrent and mild) and anxiety were noted. Claimant was found markedly limited in performing various activities which included the following: planning activities for others, performing repetitive or short cycles of work, influencing people's opinions, performing a variety of duties, expressing personal feelings, dealing with people, and working independently and around others.

Hospital documents (Exhibits 90, 98-101) from an admission dated February 24, 2011 were presented. It was noted that Claimant underwent closed reduction and splinting of an ankle fracture on February 14, 2011. A discharge date of February 25, 2011 was noted.

Physician office visit notes (Exhibits 95 and 97) dated May 19, 2011 were presented. It was noted that Claimant reported weakness following recent binge drinking. Claimant alleged that her weakness was caused by an unspecified trauma during a recent hospital encounter.

A psychiatric examination report dated April 30, 2012 (Exhibits 60-70; A31) was presented. The report was completed by a consultative psychiatrist. It was noted that the author examined Claimant and reviewed a neurological examination report and Claimant's mental health records. It was noted that Clamant presented as fatigued, irritable, and demonstrating theatrics. It was noted that Claimant reported that she cannot return to work because she cannot type because of a stroke. It was noted that Claimant reluctantly conceded improved speech and right-hand function since having a stroke. It was noted that Claimant was thought to exaggerate her symptomology. It was noted that Claimant could not currently return to work but that Claimant did not want to do so. It was noted that Claimant may be able to return to work within 8 weeks with more appropriate and aggressive psychiatric intervention. A guarded prognosis was noted. Current diagnoses of major depressive disorder (non-psychotic), alcohol dependence in questionable remission, and occupational problems were noted. Claimant's GAF was noted to be 55.

Behavioral health clinic notes (Exhibit A22-A25) dated March 14, 2013 were presented. It was noted that Claimant reported "severe" and worsening depression symptoms. It was noted that Claimant could not afford prescribed medications and had no health insurance. Claimant's GAF was noted to be 50.

Hospital documents (Exhibits A32-A33) from an admission dated September 23, 2013 were presented. It was noted that Claimant presented with complaints of dizziness, weakness, and depression. It was noted that Claimant thought that she had a seizure. It was noted that an EKG and a CT of Claimant's head were both negative. It was noted that Claimant was treated by a neurologist and discharged with unspecified medication. A final impression of hyperlipidemia was noted at discharge. A discharge date of September 24, 2013 was noted.

Hospital documents (Exhibits 77-86) from an admission dated December 20, 2013 were presented. It was noted that Claimant presented with complaints of lumbar pain, ongoing for 3 days. Radiology was noted to demonstrate mild diverticulosis, several non-obstructive renal calculi, and small hiatal hernia. Claimant's back pain was noted as resolved before discharge. Noted discharge diagnoses included hypokalemia, tachycardia, and pancytopenia likely associated with chronic alcohol abuse.

Physician office visit notes (Exhibits 53-55) dated January 17, 2014 were presented. It was noted that Claimant reported increased depression symptoms (e.g. sadness, anhedonia, poor appetite, insomnia, paranoia, and binge drinking). A decrease in Claimant's concentration was noted. Claimant was advised to abstain from alcohol. Claimant's GAF was noted to be 50. Claimant's highest GAF over the last 12 months

was noted to be 55. Medications of Zoloft, Valium, and Trazadone were noted as continued.

Behavioral health clinic notes (Exhibit A19-A21) dated January 17, 2014 were presented. It was noted that Claimant was tearful and depressed. Claimant's GAF was noted to be 50.

Physician office visit notes (Exhibit 75) dated March 19, 2014 were presented. It was noted that Claimant reported being sexually assaulted two months earlier. It was noted that Claimant was sent to the emergency room after reporting suicidal ideation. It was noted that Claimant was not taking medications as prescribed due to financial restraints.

An Initial psychosocial dated April 18, 2014 (Exhibits 27-43) was presented. The report was completed by a social worker from a treating mental health agency. It was noted that Claimant reported physical and mental health obstacles. Claimant reported that her goals included being a productive member of society and to have a better relationship with her daughter. Claimant reported strengths in confidence, learning quickly, working at projects, typing, and power point presentations.

A Psychiatric Evaluation (Exhibits 23-28) dated April 21, 2014 was presented. It was noted that Clamant abused alcohol as recently as 2 weeks prior to the evaluation. Reported problems included the following: mood swings, racing thoughts, paranoia, insomnia, poor ADLs, and an unspecified weight loss. Notable assessments included the following: unremarkable appearance, unremarkable motor status, labile and full-range affect, irritable and anxious mood, paranoid ideation, unremarkable perception, difficult immediate memory, fair insight, fair judgment, and orientation x3. An Axis I diagnosis of major depressive disorder (recurrent) was noted. A recommendation of outpatient services, alcohol treatment, and case management services was noted.

Behavioral clinic notes (Exhibit A14-A16) dated July 22, 2014 were presented. It was noted that Claimant reported ongoing occupational, social, and financial functioning difficulties. Current symptoms were noted to include paranoia about hospital staff actions and statements, agitation, and sadness over finances. A poor prognosis was noted. Claimant's GAF was 55. A plan of continuing medications was noted.

Behavioral clinic notes (Exhibit A13) dated September 25, 2014 were presented. It was noted that Claimant called a nurse and reported that she was depressed, tearful, and not able to leave her home.

Physician office visit notes (Exhibits A9-A12) dated October 30, 2014 were presented. It was noted that Claimant reported ongoing occupational, social, and financial functioning difficulties. Current symptoms were noted to include tearfulness, anhedonia, paranoia, and sadness. It was noted that Claimant was not treatment compliant. Claimant's GAF was 50. Plans of continuing psychotherapy and medications were noted.

A Psychiatric/Psychological Examination Report (Exhibits 16-18) dated November 11, 2014 was presented. The form was completed by a treating psychiatric mental health nurse practitioner with an approximate one year history of treating Claimant. It was noted that Claimant frequently missed appointments or attended them late. It was noted that Clamant was disorganized, had trouble focusing, and experienced intense emotions. Claimant's noted prescriptions included Trileptal, Valium, Zoloft, and Trazadone. Mental status examination notes included poor memory, poor concentration, disorganized thought pattern, tangential loose associations, tearfulness, poor judgment, and paranoia. Diagnoses of depression, anxiety, insomnia, and moderate mood disorder were noted. Claimant's GAF was noted to be 50.

Physician office visit notes (Exhibits A6-A8) dated January 16, 2015 were presented. It was noted that Claimant reported ongoing occupational, social, and financial functioning difficulties. Claimant's engagement with ongoing treatment was described as "partial." It was noted that Claimant recently failed to attend an appointment for fibroid surgery and an appointment with a consultative mental examiner. It was noted that Claimant was not medication compliant. Claimant's GAF was 50. Plans of continuing psychotherapy and medications were noted.

A mental status examination report (Exhibits 4-8) dated January 24, 2015 was presented. The report was noted as completed by a consultative licensed psychologist. Reported Claimant symptoms included anhedonia, social isolation, and self-neglect. It was noted that Claimant reported three previous hospitalizations related to suicidal ideation. It was noted that three previous alcohol-related hospitalizations were reported. Notable observations of Claimant made by the consultative examiner included the following: depressed affect, labile mood, tense and anxious appearance, expressing low self-esteem, mostly logical mental thought content, mostly clear speech, and orientation x3. The examiner diagnosed Claimant with major depressive disorder (mild and recurrent) and alcohol use disorder (mild). The examiner opined that Claimant demonstrated at least slight deficits in judgment, vocabulary, and abstract thinking. The examiner concluded that Claimant had intact attention and concentration. The examiner concluded that Claimant displayed no memory deficits. It was noted that Claimant's mood disorder was not well controlled at that time. The examiner opined that Claimant would have difficulty performing work involving complex verbal or written instruction, even if supervised. It was further noted that Claimant's work would be restricted by her ability to control her mood and maintain sobriety.

Physician office visit notes (Exhibits A28-A31) dated July 8, 2015 were presented. Active Claimant problems included the following: HTN, acute myocardial infarction, mood problem, chronic arterial stroke, synostosis, ankle fracture, great toe bunion, digital nerve neuroma, anxiety, depression, back pain, vaginal bleeding, hypokalemia, alcoholic abuse, and painful orthopedic hardware. Claimant's active medications included the following: aspirin, ascorbic, capsaicin, diazepam, gabapentin, ibuprofen, Lotrisone cream, ketoconazole, omeprazole, oxcarbazepine, potassium chloride, ranitidine, senna-docusate, sertraline, trazadone, and tretinoin.

Claimant testified that she had numerous complaints about the consultative mental status examination report. Claimant testified that the examination only took 20 minutes. Claimant testified to the following, in opposition to statements made within the report: she does not drive only because she has seizures, she does not take Percocet but takes other medications which were not listed, she moved to Michigan when she was 8 years old (not 9 years old), she has a diverse employment and only worked for one accounting firm, she was not asked about math questions, and all of her symptoms were not factored. Despite Claimant's lengthy complaint list, Claimant's complaints were somewhat contradictory with her contention. Claimant disparaged the quality of the report, yet she also contended that the examiner's conclusions were correct.

Claimant testified that she had a stroke in 2010. Claimant testified that she still has limited right-side usage. Claimant testified that her ankle swells with extended walking. Claimant also testified that she's had 4 seizures in her life and that seizures are ongoing problems.

The overwhelming majority of presented evidence concerned Claimant's mental health. Though Claimant may have exertional restrictions, presented evidence was not particularly supportive. One hospitalization for a self-described seizure was verified, however, radiology was negative and there was not a physician reference to a seizure. Presented documents verified that Claimant had a stroke 5 years earlier and broke an ankle four years earlier. Claimant presented insufficient evidence of ongoing exertional restrictions.

Claimant testified that she has difficulty with memory, concentration, depression, and anxiety. Claimant's testimony was consistent with presented documents. Presented documents further established that Claimant's mental health has been restricted for several years. Claimant testified that she has seen a psychiatrist since the 1990s and currently sees a psychiatrist once per month. Claimant also testified that she regularly sees a therapist.

It is found that Claimant established significant psychological impairments to performing 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 bipolar disorder. Bipolar disorder is an affective disorder covered by Listing 12.04 which reads as follows:

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. 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 C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:
    a. Anhedonia or pervasive loss of interest in almost all activities; or
    b. Appetite disturbance with change in weight; or
    c. Sleep disturbance; or
    d. Psychomotor agitation or retardation; or
    e. Decreased energy; or
    f. Feelings of guilt or worthlessness; or
    g. Difficulty concentrating or thinking; or
    h. Thoughts of suicide; or
    I. Hallucinations, delusions, or paranoid thinking

OR

2. Manic syndrome characterized by at least three of the following:
    a. Hyperactivity; or
    b. Pressure of speech; or
    c. Flight of ideas; or
    d. Inflated self-esteem; or
    e. Decreased need for sleep; or
    f. Easy distractibility; or
    g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
    h. Hallucinations, delusions or paranoid thinking

OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

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. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Claimant testimony and presented records verified ongoing struggles with anhedonia, weight disturbance, sleep disturbance, concentration difficulties, and decreased energy. It is found that Claimant meets Part A of the above listing.

Claimant's psychiatrist completed a Mental Residual Functional Capacity Assessment (Exhibits 21-22); the form was dated October 13, 2014. Claimant's psychiatrist found Claimant to be markedly restricted in 12/20 work-related abilities which included the following:

- Remembering locations and other work-like procedures
- Understanding and remembering 1 or 2-step directions
- Understanding and remembering detailed instructions
- Carrying out simple 1-2 step directions.
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Performing activities within a schedule and maintaining attendance and punctuality
- Sustaining an ordinary routine without supervision
- Working in coordination or proximity to other without being distracting
- Making simple work-related decisions
- Completing a normal workday without psychological symptom interruption
- Responding appropriately to changes in the work setting
- Setting realistic goals or making plans independently of others.

A Mental Residual Functional Capacity Assessment (Exhibits 19-20) dated October 20, 2014 was presented. The assessment was noted as completed by a treating psychiatric mental health nurse practitioner. This form lists 20 different work-related activities among four areas: understanding and memory, sustained concentration and persistence, social interaction and adaptation. A therapist or physician rates the patient's ability to perform each of the 20 abilities as either "not significantly limited", "moderately limited", "markedly limited" or "no evidence of limitation". It was noted that

Claimant was markedly restricted in 13/20 of the form's listed work-related abilities which included:

- Remembering locations and other work-like procedures
- Understanding and remembering 1 or 2-step directions
- Understanding and remembering detailed instructions
- Carrying out detailed instructions
- Maintaining concentration for extended periods
- Performing activities within a schedule and maintaining attendance and punctuality
- Sustaining an ordinary routine without supervision
- Working in coordination or proximity to other without being distracting
- Completing a normal workday without psychological symptom interruption
- Interacting appropriately with the general public
- Accepting instructions and responding appropriately to criticism
- Getting along with others without exhibiting behavioral extremes
- Responding appropriately to changes in the work setting

Both presented Mental Residual Functional Capacity Assessments were consistent with marked restrictions to persistence and social interactions. Marked restrictions were also consistent with a consistent GAF of 50. The Diagnostic and Statistical Manual of Mental Disorders (4^{th} 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 found that Claimant meets Part B of the affective disorder listing.

Based on the presented evidence, Claimant meets the listing for affective disorders. Before a determination of disability may occur, Claimant's alcohol abuse must be factored.

When drug and/or alcohol abuse (DAA) is applicable, SSA applies the steps of the sequential evaluation a second time to determine whether the claimant would be disabled if he or she were not using drugs or alcohol. SSR 13-2p. It is a longstanding SSA policy that the claimant continues to have the burden of proving disability throughout the DAA materiality analysis. *Id.* Noted considerations made by SSA concerning drug materiality include the following:

- Does the claimant have DAA?
- Is the claimant disabled considering all impairments, including DAA?
- Is DAA the only impairment?
- Is the other impairment disabling by itself while the claimant is dependent upon or abusing drugs and/or alcohol?
- Does the DAA cause or affect the claimant's medically determinable impairments?
- Would the other impairments improve to the point of non-disability in the absence of DAA

Claimant testified that she last drank a couple of months ago. Claimant testified that she tends to return to alcohol when she deals with a bad event. Claimant estimated that she drank alcohol 5-6 times in the last 12 months.

Claimant is not doing herself any favors by continuing her alcohol abuse. Presented evidence did not suggest that Claimant's alcoholic abuse was a significant factor to causing Claimant mental health restrictions. A long history of depression symptoms and psychiatric treatment was established. Though alcoholic abuse was regularly noted as a problem, it was not noted to be a significant factor in Claimant's sporadic mental health.

Presented records regularly noted that Claimant's participation and compliance with treatment was erratic. It is also notable that physicians noted that Claimant appears to exaggerate symptoms and display little interest in returning to employment. Claimant's lack of effort and compliance could be perceived as material to a finding of disability. If noncompliance is found to be material, a finding of disability would be negated. Though presented evidence provided some insight into Claimant's noncompliance, it cannot be stated with probability that Claimant's functioning would improve if she attended every medical appointment and took all prescribed medication. It is also notable that the bulk of Claimant's noncompliance appeared to be related to financial difficulties (e.g. lack of transportation and lack of health insurance.

It is found that alcohol abuse and medical noncompliance are not material to a finding of disability. Accordingly, Claimant is disabled and it is found that MDHHS improperly denied Claimant's SDA application.

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 January 5, 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: July 21, 2015

Date Mailed: July 21, 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: [redacted]