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

IN THE MATTER OF:

[redacted]

MAHS Reg. No.: 15-018807
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: February 1, 2016
County: Wayne (18)

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION

Following Petitioner'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; and Mich Admin Code, R 792.11002. After due notice, an in-person hearing was held on February 1, 2016, from Taylor, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], medical contact worker.

ISSUE

The issue is whether MDHHS properly terminated Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner 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. Petitioner was an ongoing SDA benefit recipient.

2. Petitioner's only basis for SDA eligibility was as a disabled individual.

3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual for purposes of SDA eligibility (see Exhibit 1, pp. 2-7).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective November 2015, and mailed a Notice of Case Action (Exhibit 1, pp. 692-694) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits.

6. Petitioner alleged disability based on restrictions related to psoriatic arthritis, hip pain, low-hanging testicles, carpal-tunnel syndrome (CTS), and anxiety.

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 (7/2014), 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.

Generally, state agencies such as MDDHS 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. The definition of SDA disability is identical except that only a three month period of disability is required.

Substantial gainful activity 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. BEM 260 (7/2014), p. 10. 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 substantial gainful activity. *Id*.

Once an individual has been found disabled for purposes of disability-related benefits, continued entitlement is periodically reviewed in order to make a current determination or decision as to whether disability remains in accordance with the medical improvement review standard. 20 CFR 416.993(a); 20 CFR 416.994. Petitioner was previously certified by the MRT as unable to work for at least 90 days. At Petitioner's most recent SDA benefit redetermination, MDDHS determined that Petitioner was no longer disabled.

In evaluating a claim for ongoing disability benefits, federal regulations require a sequential evaluation process be utilized. 20 CFR 416.994(b)(5). The review may cease and benefits continued if sufficient evidence supports a finding that an individual is still unable to engage in substantial gainful activity. *Id.* Prior to deciding if an individual's disability has ended, the department will develop, along with the petitioner's cooperation, a complete medical history covering at least the 12 months preceding the date the individual signed a request seeking continuing disability benefits. 20 CFR 416.993(b). The department may order a consultative examination to determine whether or not the disability continues. 20 CFR 416.993(c).

The below-described evaluation process is applicable for clients that have not worked during a period of disability benefit eligibility. There was no evidence suggesting that Petitioner received any wages since receiving disability benefits; thus, the analysis may commence.

The first step in the analysis in determining the status of a petitioner's disability requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue and no further analysis is required. This consideration requires a summary and analysis of presented medical documents.

Mental health case management notes (Exhibit 1, pp. 29-30, 150-151) dated [redacted] were presented. It was noted Petitioner needed a letter for his probation officer that he was receiving mental health services.

Mental health case management notes (Exhibit 1, pp. 27-28, 148-149) dated [redacted], were presented. It was noted Petitioner received assistance with disability documents.

Mental health case management notes (Exhibit 1, pp. 25-26, 146-147) dated [redacted], were presented. It was noted Petitioner's social worker attended a home visit because Petitioner reported motion sickness would make it difficult for him to attend appointments.

An addendum to a treatment plan (Exhibit 1, pp. 20-24, 141-145) dated [redacted], [redacted] was presented. Various discussions included coping with anxiety, dealing with being on probation, and finding independent housing.

A Medication Review Note dated [redacted] (Exhibit 1, p. 138) was presented. It was noted Petitioner reported taking Seroquel when he feels giddy.

Medication review notes (Exhibit 1, p. 19) dated [redacted], were presented. It was noted Petitioner reported anxiety symptoms were "markedly" improved. It was noted Petitioner was hyper verbal and constantly discussed physical problems.

Mental health case management notes (Exhibit 1, pp. 17-18, 136-137) dated [redacted], were presented. It was noted Petitioner was assisted with various insurance documents he did not understand.

Mental health case management notes (Exhibit 1, pp. 55-56, 134-135) dated [redacted], were presented. It was noted Petitioner received help in understanding disability application documents.

Various mental health case management notes (Exhibit 1, pp. 36-50, 86-90, 97-98, 99-102, 109-119, 122-133) dated [redacted], were presented. Observations of Petitioner included the following: good judgment, distractible concentration, alert, impaired recent memory, normal thought process, and normal stream of mental activity. It was noted Petitioner was independent in performing daily activities. It was noted Petitioner was a daily marijuana user; a recommendation to quit was noted. Prescribed medications included Xanax and Seroquel. Petitioner was noted to be a low risk for suicide. Axis I diagnoses of cannabis dependence and major depressive disorder (mild and recurrent). Petitioner's GAF was 50 as of [redacted].

An Adult Health Assessment from a treating nurse (Exhibit 1, pp. 91-96, 103-108) dated [redacted], was presented. Petitioner reported problems of loss of appetite, right shoulder pain radiating to his jaw, psoriatic pain, and joint pain. Medications of Marinol and oxycodone were noted as current medications.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 84-85, 183-184) dated [redacted], were presented. Petitioner's upcoming court dates were discussed.

Treatment Plan Meeting and progress notes (Exhibit 1, pp. 75-81, 174-18-182) dated [redacted], were presented. Various therapy goals and objectives were discussed. It was noted Petitioner expressed discontent at some prescribed goals which failed to acknowledge his physical health obstacles.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 73-74, 172-173) dated [redacted], were resented. It was noted Petitioner was upset over a legal obligation to complete 80 hours of community service.

Medication review notes dated [redacted] (Exhibit 1, p. 171) from a treating psychiatrist were presented. Effexor was noted as prescribed.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 70-71, 169-170) dated [redacted], were presented. It was noted Petitioner was seeing a rheumatologist.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 68-69, 167-168) dated [redacted], were presented. It was noted Petitioner received help in understanding MDHHS redetermination documents. It was noted Petitioner reported he was incapable of performing court ordered community service.

Nursing progress notes dated [redacted] (Exhibit 1, pp. 165-166) were presented. Unspecified prescriptions were noted as continued.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 64-65, 163-164) dated [redacted], were presented. It was noted Petitioner reported needing no resources.

An addendum to a treatment plan (Exhibit 1, pp. 156-162) dated [redacted], was presented. Various goals (e.g. increasing confidence, not going to Walmart) were discussed.

Mental health nursing progress notes from a treating nurse (Exhibit 1, pp. 62-63, 154-155) dated [redacted], were presented. It was noted Petitioner reported losing prescription papers.

Mental health progress notes from a treating social worker (Exhibit 1, pp. 60-61, 152-153) dated [redacted], were presented. It was noted Petitioner began to grow a marijuana garden.

A letter from Petitioner's PCP (Exhibit 1, p. 244) dated [redacted], was presented. The physician stated Petitioner was "permanently disabled" due to unspecified "multiple disabilities." Restrictions included difficulties with standing and walking for extended periods. It was noted Petitioner had difficulty with getting in and out of cars. Unspecified range of motion restrictions were noted. It was noted Petitioner used a cane due to problems with shoulders, neck, chest, arms, hips, legs, hands, and fingers. It was noted Petitioner had inflamed hip joints making breathing difficult. Walking around the house and getting out of bed were described as "nearly impossible." It was noted Petitioner had "extreme fatigue" which was "unbearable." It was noted Petitioner had feet and ankle stiffness which made him a high risk for falling. Putting a key in the ignition and

turning it was described as “nearly impossible.” Any straining of joints was discouraged due to the risk of aggravating arthritis.

Hospital emergency room documents (Exhibit 1, pp. 211-240) dated [redacted], were presented. It was noted that Petitioner sought pain medications due to body pain. Physical examination findings included normal gait, no obvious musculoskeletal deformity, and intact sensation. It was noted Petitioner received an oral dose of pain medication and was then discharged. Diagnoses of acute exacerbation of chronic pain and chronic narcotic use were noted.

Hospital emergency room documents (Exhibit 1, pp. 191-210) dated [redacted], were presented. It was noted that Petitioner presented seeking pain medications with complaints of body pain. It was noted Petitioner received 490 pills since March 31 (noted to be an average of 9 per day). It was noted Petitioner blamed “dumb, stupid blonds” as to why he did not have his pain medication. Petitioner was advised to see his physician for pain medication. A final diagnosis of acute exacerbation of pain, drug-seeking behavior, and chronic narcotic abuse was noted.

A Medical Examination Report (Exhibit 1, pp. 10-11, 268-270) dated [redacted], was presented. The form was completed by an internal medicine physician (Petitioner’s PCP) with an approximate 2 year history of treating Petitioner. Petitioner’s physician listed diagnoses of psoriatic arthritis, fatigue, chronic pan syndrome, bipolar disorder, and autoimmune difficulty. Current medications included Xanax, Naproxen, Flexeril, oxycontin, and oxycodone. An impression was given that Petitioner’s condition was deteriorating. Physical examination findings noted synovitis in right wrist, tight leg, and PIP joints. It was noted that Petitioner could not meet unspecified household needs. It was noted that Petitioner did not need an assistive device for ambulation. Mental restrictions of comprehension, memory, concentration, following simple instructions, reading/writing, and social interaction were noted. Petitioner’s physician stated Petitioner had various limitation(s) expected to last 90 days. The physician opined that Petitioner was restricted to less than 2 hours of standing over an eight-hour workday. Sitting restrictions were not stated. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Petitioner’s physician opined that Petitioner was restricted from performing the following repetitive actions: simple grasping, reaching, pushing/pulling, fine manipulating, and operating leg/foot controls. In response to a question asking for the stated basis for restrictions, Petitioner’s physician cited psoriatic arthritis.

A mental status examination report (Exhibit 1, pp. 13-14, 121) dated [redacted], was presented. The report was noted as completed by a consultative psychiatrist. Petitioner reported a history of cutting, in part, due to struggles with sexuality (he last cut over a year earlier). Petitioner reported a history of 5 psychiatric hospitalizations (2012 being the most recent). Reported symptoms included night terrors, paranoia, and social isolation. Two previous suicide attempts were noted, one where he ingested rubbing alcohol and a second where he cut his face. A recommendation of continued

psychiatric and physical treatment was recommended. Diagnoses of major depressive disorder and abuse of nicotine and cannabis were noted. A guarded prognosis was noted.

Petitioner alleged disability, in part, due to a learning disability. Petitioner could not state what specific disability he has. Petitioner alleged he is somewhat illiterate and has difficulty with comprehension. Petitioner's testimony was supported by statements by his PCP on a Medical Examination Report. The statements by Petitioner and his PCP were not supported by any objective medical evidence.

Petitioner testified he was diagnosed with a varicocele in 2013. A varicocele is understood to be a testicular blood flow issue. Petitioner testified his testicles hang too low which causes him pain and nausea. Petitioner testified he has testicular pain for 15 minutes every day. Petitioner's testimony was not supported by any recent treatment records.

Petitioner testified he has misaligned hips. Petitioner testified the misalignment causes him to experience pain when sitting, standing, and ambulation. Petitioner testified he utilizes a cane and a knee brace. Petitioner testified he takes Norco, Naproxen, and marijuana to treat his pain.

Petitioner testified he has CTS in his right wrist. The diagnosis is consistent with repetitive action restrictions stated by Petitioner's PCP. The diagnosis was not well supported by recent treatment history.

Petitioner alleged that psoriatic arthritis continues to render him disabled. Petitioner testified his body was once 40% affected by psoriasis; he testified he was unsure of its current coverage. Petitioner testimony conceded his skin has since improved, however, he alleged the underlying arthritis has not improved.

Petitioner testified he can only walk ½-1 block before fatigue and hip pain prevent further ambulation. Petitioner testified he is restricted in standing to 30 minute periods. Petitioner testified he has no sitting restrictions. Petitioner testified he cannot lift more than 10 pounds.

Petitioner testified he has difficulty with daily living activities and requires the use of a caretaker. Petitioner testified he needs help shaving because of CTS. Petitioner testified he sometimes needs help buttoning his clothes. Petitioner testified he is unable to perform chores such as scrubbing floors, mowing lawn, shoveling snow, or washing dishes. Petitioner testified he can shop but needs help carrying groceries. Petitioner testified he can drive, but recently, he was physically unable to turn the ignition key.

Petitioner initially testified he could work if he was more physically able. Petitioner then testified non-exertional obstacles would prevent the performance of employment.

Petitioner testified he has a history of manic episodes. Petitioner testified he once punched a mirror during one of his manic episodes. Petitioner testified he has social phobias; as an example, Petitioner testified he does not like to be around people when his psoriasis flares. When Petitioner was asked if he could work part-time, Petitioner speculated he would likely get frustrated and hurt himself or others.

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

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

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treating physician's diagnosis of an anxiety disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner had a complete inability to function outside of the home.

A listing for inflammatory arthritis (Listing 14.09) was considered based on treatment for psoriatic arthritis. The presented medical records were insufficient to establish that Petitioner has an inability to ambulate effectively, perform fine and gross movements, or suffers inflammation or deformities with a diagnosis of ankylosing spondylitis or other spondyloarthropathies, or suffers repeated manifestations of inflammatory arthritis.

It is found Petitioner failed to meet a SSA listing. Accordingly, the analysis proceeds to the second step.

The second step of the analysis considers whether medical improvement occurred. CFR 416.994(b)(5)(ii). Medical improvement is defined as any decrease in the medical severity of the impairment(s) which was present at the time of the most favorable medical decision that the individual was disabled or continues to be disabled. 20 CFR 416.994(b)(1)(i).

The original finding of disability was based on a Hearing Decision (Exhibit 1, pp. 252-265, 678-691) dated [redacted]. The authoring administrative law judge (ALJ)

determined Petitioner had moderate non-exertional restrictions in performing basic work activities. The ALJ found that Petitioner, was at most, capable of performing sedentary employment. Based on Petitioner's combined exertional and non-exertional restrictions, Petitioner was deemed disabled. The records considered in the original finding supporting SDA disability were presented.

Various psychiatric notes (Exhibit 1, pp. 312-380, 452-522) were presented. The notes ranged from June 2013 through April 2014. Various problems of paranoia, anxiety, tobacco abuse, cannabis abuse, mood swings, and panic attacks were reported. Various medications were prescribed.

A Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 285-286) dated [redacted], was presented. The assessment was noted as completed by a social worker and cosigned by a treating psychiatrist. 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 Petitioner was markedly restricted in the following abilities: understanding and remembering detailed instructions, carrying out detailed instructions, maintaining concentration for extended periods, completing a normal workday without psychological symptom interruption, performing activities within a schedule and maintaining attendance and punctuality, and accepting instructions and responding appropriately to criticism. Petitioner was deemed moderately limited in several other abilities including: remembering locations and other work-like procedures, understanding and remembering 1 or 2-step directions, carrying out simple 1-2 step directions, sustaining an ordinary routine without supervision, working in coordination or proximity to other without being distracting, making simple work-related decisions, interacting appropriately with the general public, and getting along with others without exhibiting behavioral extremes.

A Medical Examination Report (Exhibit 1, pp. 294-295, 432-434) dated [redacted], was presented. The form was completed by a rheumatologist with an approximate 1 ½ month history of treating Petitioner. Petitioner's physician listed a diagnosis of psoriatic arthritis. An impression was given that Petitioner's condition was improving. It was noted that Petitioner can meet household needs. A need for a walking-assistance device was not indicated. Petitioner's physician stated Petitioner had various limitation(s) expected to last 90 days. The physician opined that Petitioner was restricted to less than 2 hours of standing and/or walking over an eight-hour workday. Sitting restrictions were not stated. Petitioner was restricted to occasional lifting/carrying of less than 10 pounds, never 10 pounds or more. Petitioner's physician opined that Petitioner was restricted from performing the following repetitive actions: simple grasping, reaching, pushing/pulling, fine manipulating, and operating foot/leg controls. Petitioner's rheumatologist stated joint inflammation in multiple locations justified the restrictions.

A Psychiatric Evaluation (Exhibit 1, pp. 307-310, 446-449) dated [redacted], was presented. The evaluation was completed by a psychiatrist with an unspecified history of treating Petitioner. Axis I diagnoses of cannabis dependence and major depressive disorder (recurrent and mild) were noted. Petitioner's GAF was noted to be 50 as of [redacted].

A consultative medical examination report (Exhibit 1, pp. 299-305, 438-445) dated [redacted], was presented. It was stated psoriatic arthritis was improving due to Humira treatment. It was noted Petitioner had a normal gait and showed no signs of inflamed joints. Right hand weakness (with 4th and 5th finger sensory loss) was noted. Petitioner's main problem was noted to be psychiatric. A 10 pound lifting restriction was noted. Reduced ranges of motion were noted in Petitioner's hips, left ankle, and lumbar.

Exertional restrictions stated by Petitioner's rheumatologist in 2014 mirrored more recently stated restrictions from Petitioner's PCP. The similarity in restrictions would have been more compelling had a specialist verified ongoing restrictions; Petitioner presented no recent treatment from a rheumatologist. Petitioner testified he has not seen a rheumatologist since receiving medical coverage from the state. Petitioner testified he saw one in the past but stopped because the physician did not understand his testicular pain. Despite the absence of recent specialist treatment, the similarity in physical restrictions was supportive in finding a lack of improvement.

Recent psychiatric treatment documents did not specify restrictions, though they were not particularly indicative of improvement. A Petitioner statement of marked improvement was noted. Other evidence was less supportive in finding improvement.

The most insightful comments of Petitioner's updated mental condition came from a consultative psychiatrist who stated Petitioner could not "function on a fully sustained basis" at that time (see Exhibit 1, p. 13). The guarded prognosis was also indicative of a lack of medical improvement.

Based on presented evidence, it is found MDHHS failed to establish medical improvement. Accordingly, the analysis may proceed directly to the fourth step.

Step 4 of the analysis considers whether any exceptions apply to a previous finding that no medical improvement occurred or that the improvement did not relate to an increase in RFC. 20 CFR 416.994(b)(5)(iv). If medical improvement related to the ability to work has not occurred and no exception applies, then benefits will continue. CFR 416.994(b). Step 4 of the disability analysis lists two sets of exceptions.

The first group of exceptions allow a finding that a claimant is not disabled even when medical improvement had not occurred. The exceptions are:

(i) Substantial evidence shows that the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work;

(ii) Substantial evidence shows that the individual has undergone vocational therapy related to the ability to work;
(iii) Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the impairment(s) is not as disabling as previously determined at the time of the most recent favorable decision;
(iv) Substantial evidence demonstrates that any prior disability decision was in error.
20 CFR 416.994(b)(4)

If an exception from the first group of exception applies, then the claimant is deemed not disabled if it is established that the claimant can engage is substantial gainful activity. If no exception applies, then the claimant's disability is established.

The second group of exceptions allow a finding that a claimant is not disabled irrespective of whether medical improvement occurred. The exceptions are:
(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperate;
(iii) The individual cannot be located;
(iv) The prescribed treatment that was expected to restore the individual's ability to engage in substantial gainful activity was not followed.
20 CFR 416.994(b)(4)

Presented evidence was indicative of many obstacles to a disability finding. Petitioner's work history was highly unremarkable. Petitioner has at least one documented hospital encounter where he exhibited drug seeking behavior. Updated rheumatology records were not presented; such records could have provided objective medical evidence supporting disability. Physical restrictions stated by a PCP were not well supported with objective findings (e.g. blood testing, radiology, statements of psoriasis body coverage…). Mental health treatment documents referenced some improvement. Petitioner's primary psychiatric diagnosis was cannabis dependence; cannabis dependence is not a diagnosis which can justify mental health restrictions. Petitioner's other diagnosis of "mild" depression was also not indicative of disability.

Despite many obstacles to support a statement of disability, it cannot be stated that any of the above exceptions are applicable. It is found that Petitioner is still a disabled individual. Accordingly, it is found that MDHHS improperly terminated Petitioner's SDA eligibility.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly terminated Petitioner's eligibility for SDA benefits. It

is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA eligibility, effective November 2015;
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner 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 no less than twelve months from the date of this administrative decision, if Petitioner 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: **FEBRUARY 23, 2016**

Date Mailed: **FEBRUARY 23, 2016**

CG / hw

NOTICE OF APPEAL: A party may appeal this Hearing Decision in the circuit court in the county in which he/she resides, or the circuit court in Ingham County, within 30 days of the receipt date. A copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Hearing Decision from 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]