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

IN THE MATTER OF:

MAHS Reg. No.:	15-019543
Issue No.:	4009
Agency Case No.:	
Hearing Date:	January 28, 2016
County:	Kent

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, a telephone hearing was held on January 28, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , supervisor, and , specialist.

ISSUE

The issue is whether MDHHS properly denied 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. On , Petitioner applied for SDA benefits.

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

3. On , the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 1-4).

4. On MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On , Petitioner requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Petitioner was a 48-year-old male.

7. Petitioner does not have current earnings amounting substantial gainful activity income limits.

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

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

10. Petitioner alleged disability based on restrictions related to body pain, various immune system disorders, and various psychological disorders.

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).

Petitioner's hearing request noted a dispute of Family independence Program (FIP) (cash) benefits. FIP is a MDHHS program available to caretakers of minor children and pregnant women. Petitioner testified a dispute of SDA benefits was intended. MDHHS was not confused by Petitioner's request to dispute FIP eligibility and was prepared to defend a denial of Petitioner's SDA application. It is found that Petitioner intended to dispute SDA eligibility and the hearing was conducted accordingly.

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 Petitioner. Accordingly, Petitioner may not be considered for SDA eligibility without undergoing a

medical review process (see BAM 815) which determines whether Petitioner 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. SDA differs in that a 90 day period is required to establish 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 CFR 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. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner 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 durational 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 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 petitioners 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 requirements are 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 Petitioner'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.

Medical records from 2003 through 2013 (Exhibit 1, pp. 49-121, 194-318) were presented. A 2011 colonoscopy was noted to be normal. A 2011 abdominal ultrasound was noted to be normal. Physician office visits for the following complaints were noted: sinus infection, swollen eye following a fight (stated to be alcohol related), neck pain with arm numbness, abdominal pain, ETOH abuse, and suspected drug overdose with alcohol intoxication. Ongoing treatments for HIV, hyperlipidemia, gout, anxiety disorder, depression, sinusitis, constipation, ETOH abuse, and cervicalgia were noted.

An X-ray report of Petitioner's hips, left hip, ankles, and left foot dated February 8, 2014 (Exhibit 1, pp. 192-194) was presented. The x-rays were taken in response to a fall from

3 days earlier. Degenerative changes were noted in Petitioner's left hip. Soft tissue swelling was noted in Petitioner's left ankle. Tiny plantar spurs were noted in Petitioner's ankle. An overall impression of no acute osseous abnormality in all viewed areas was noted.

Various immunologist office visit notes and lab work from 2014 (Exhibit 1, pp. 142-188) was presented. Notable HIV findings were not apparent.

A CT report of Petitioner's brain (Exhibit 1, pp. 191) dated [redacted], was presented. The radiology was performed in response to unspecified head trauma. An impression of a negative CT was noted.

A CT report of Petitioner's head (Exhibit 1, pp. 189-190) dated [redacted], was presented. The radiology was performed in response to complaints of dizziness. An impression of no evidence of significant abnormality was noted.

Immunologist office visit notes (Exhibit 1, pp. 135-139) dated [redacted], were presented. It was noted Petitioner began HAART therapy the previous week. Petitioner reported having issues with his parents. Petitioner reported stopping alcohol use 3 weeks earlier. A follow-up in 3 months was planned.

Immunologist office visit notes (Exhibit 1, pp. 130-134) dated [redacted], were presented. It was noted Petitioner had an alcohol relapse since his last appointment in January 2015. A pain level of 6/10 (with unspecified source) was noted.

Immunologist office visit notes (Exhibit 1, pp. 122-129) dated [redacted], were presented. Pertinent negatives included the following: abdominal pain, depression, anxiety, diarrhea, chills, fatigue, headache, myalgia, weight loss, and sore throat. Numbness of feet/toes (pain level 3/10) was noted. Petitioner reported he "started drinking again" the previous night. CD4 percent and CD8 percent were both noted to be normal. A referral to a dermatologist for an assessment of dermatitis was noted.

A medical examination report (Exhibit 1, pp. 5-9) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of HIV, hepatitis, fibromyalgia, neuropathy, and chronic diarrhea. Petitioner reported a 15 pound weight loss from the prior year. Petitioner reported his last CD4 count was 684 and his viral load was undetectable. Petitioner blamed his leg neuropathy on his various medications. Petitioner reported a walking capability of 3 blocks. Petitioner reported a lifting ability of 10 pounds. A sitting capability of 1-2 hours was reported. Mild difficulty performing heel and toe walking, squatting, and standing on either foot for 3 seconds was noted. All ranges of motions were normal. Diminished neurological sensation was noted from both ankles. It was noted Petitioner walked with a mildly guarded gait. It was noted Petitioner showed signs of fibromyalgia, though active synovitis or tender points were not present that day.

A mental status examination report (Exhibit 1, pp. 10-16) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported difficulty with concentration and depression episodes causing him to excessively drink. Petitioner reported no recent suicidal ideation, though a history of suicidal thoughts was noted. Psychiatric hospitalizations from his early adulthood were noted. Petitioner reported shopping causes anxiety so severe that he feels like he will faint. Petitioner reported a history of hallucinations after periods of excessive drinking. It was noted Petitioner was currently a caretaker for his elderly parents. Petitioner reported being "obsessed about being heavy." General Ability Measure for Adult (GAMA) testing indicated an IQ of 90 which placed Petitioner at the low end of the average range. It was noted Petitioner's score indicated no concerns for intellectual disability. Beck Depression Inventory-II testing, a self-reporting test, demonstrated "severe" depression. It was noted Petitioner showed symptoms of attention deficit. The examiner noted diagnoses of major depressive disorder (moderate, with anxious distress), alcohol use disorder (moderate), ADD/ADHD, and borderline personality disorder (moderate). The examiner stated Petitioner could not manage funds due to alcohol abuse.

Petitioner alleged disability, in part, due to HIV and hepatitis. Petitioner was diagnosed with HIV in 2002 (see Exhibit 1, p. 5). Petitioner testified he is compliant with medications. Petitioner testimony conceded his T-cell count is good and that HIV is undetectable. Petitioner's testimony was consistent with presented treatment and lab work.

Petitioner testified he has recurrent skin lesion on his foot. Treatment records indicated Petitioner was referred to a dermatologist, though specialist records were not apparent.

Petitioner testified he has body pain. Petitioner testified he was diagnosed with fibromyalgia. The diagnosis was not apparent. Treatments and diagnoses for myalgia and toe/foot neuropathy were established.

Petitioner testified he has chronic diarrhea. Petitioner testified that the cause is not known. Petitioner testified he does not wear adult diapers. Petitioner testimony estimated he had bowel incontinence 3 times over the previous 4 months; Petitioner testified he has not had any accidents since taking Lomotil. Petitioner testified he adjusted the time he takes medications and now only experiences diarrhea in the morning. Petitioner testified he was referred to an endocrinologist for the problem. Petitioner testified his endocrinologist also treats him for fatty liver disease. Specialist treatment documents were not apparent.

Petitioner testified he has concentration difficulties. Petitioner testified he is treated for anxiety and depression by his primary care physician.

Petitioner testified he has a history of alcohol abuse. Petitioner testified he last drank on [redacted].

Petitioner testified he has walking, lifting, and standing restrictions due to his various problems. Petitioner also testified he has concentration difficulties and anxiety. Petitioner's medical documents sufficiently verified a probability of exertional and non-exertional restrictions that have lasted for at least 90 days. Accordingly, the analysis may proceed to the third step.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for chronic skin infections (Listing 8.04) was considered based on a diagnosis for dermatitis. The listing was rejected due to a failure to establish extensive fungating or extensive ulcerating skin lesions that persist for at least 3 months despite continuing prescribed treatment.

A listing for peripheral neuropathies (Listing 11.14) was factored based on a neuropathy diagnosis. The listing was rejected due to a failure to establish significant and persistent disorganization of motor function in two extremities.

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 HIV (Listing 14.08) was considered. Petitioner did not establish listing requirements for bacterial infections, fungal infections, viral infections, malignant neoplasms, skin conditions, HIV wasting syndrome, HIV encephalopathy, diarrhea resistant to treatment, or other listing requirements.

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

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id.*

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified he has a history of employment in the mortgage industry. Petitioner testified he worked over 10 years within the mortgage title insurance field. Petitioner testified he worked several jobs since 2011 (e.g. factory line worker), most through a temp agency. Petitioner testimony conceded that his alcohol use was a factor in some of his job terminations. The analysis of whether Petitioner can perform his past employment as a title insurer (a sedentary job) will be reserved for the final step of the analysis.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight

lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner testimony estimated he can walk for 15-20 minutes before his legs become numb. Petitioner testified a comparable restriction for standing. Petitioner testified he has no problems with sitting. Petitioner testified his lifting is limited to 10 pounds due to back pain. Petitioner testified he sometimes uses a cane though he conceded he does not need it most of the time.

Petitioner testified he sometimes gets dizzy when showering; Petitioner speculated that dizziness could be one of his medication side effects. Petitioner testified he tries not to shop alone in case he gets dizzy. Petitioner also testified he sometimes feels like everyone is watching him when he shops. Petitioner testified he has no problems with driving, dressing, grooming, and laundry.

Physician statements of Petitioner restrictions were not presented. Restrictions can be inferred based on presented documents.

Presented evidence established some treatment for neuropathy, though neurological testing was not apparent. Though Petitioner testified he uses a cane, he conceded a physician has not prescribed him one. Diminished neurological sensation in the ankles and a mildly guarded gait were noted by a consultative examiner, however, neither condition precludes the performance of sedentary employment such as mortgage title insurer.

Petitioner has life-threatening diagnoses of HIV and hepatitis. Presented records tended to verify the diseases are well managed and cause Petitioner few, if any, exertional problems.

Petitioner is deemed capable of performing the exertional requirements of all sedentary employment including his former employment involved in title insurance. The analysis will proceed to consider Petitioner's non-exertional restrictions.

The most compelling evidence of non-exertional symptoms came from a consultative psychologist. The examiner concluded Petitioner's psychological profile could apply to several models, though numerous and serious difficulties were major obstacles to immediate adjustment. A "limited" prognosis was given due to Petitioner's various problems. The statements are suggestive of non-exertional restrictions which might preclude Petitioner's performance of any employment. The statements must be considered in context.

Petitioner presented no psychological or psychiatric treatment documents since applying for SDA benefits. Petitioner testified he has tried to see a psychiatrist since January 2015, however, his health insurance has not approved the service. The absence of counseling/therapy leaves Petitioner a reasonable avenue for improvement in his condition.

The consultative examiner noted Petitioner's substance abuse was a "significant exacerbation." The examiner further noted Petitioner may experience emotional stabilization following sobriety. Petitioner testimony conceded he did not cease alcohol consumption until several weeks after the consultative examination. Treatment documents during Petitioner's current period of sobriety were not presented.

It is appreciated that Petitioner lives with serious physical conditions which place great stress and time constraints on his life. It is appreciated that Petitioner appears to have stressors in his recent life (recent death of a partner and being a caretaker to his parents). Though Petitioner has multiple stressors, he appears to manage his life well during his current period of sobriety. This consideration supports a finding that Petitioner has no significant non-exertional restrictions while maintaining sobriety.

It is found Petitioner can perform his past employment as a title insurer. Accordingly, it is found Petitioner is not disabled and that MDHHS properly denied Petitioner's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that MDHHS properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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

Date Signed: **FEBRUARY 22, 2016**

Date Mailed: **FEBRUARY 22, 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: