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.: 15-020084
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: January 19, 2016
County: Wayne (19)

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 19, 2016, from Detroit, 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. 151-158).

4. On [redacted], MDHHS terminated Petitioner's eligibility for SDA benefits, effective November 2015, and mailed a Notice of Case Action (Exhibit 1, pp. 159-163) informing Petitioner of the termination.

5. On [redacted], Petitioner requested a hearing disputing the termination of SDA benefits (see Exhibit 1, pp. 2-3).

6. As of the date of the hearing, Petitioner was a 43-year-old female.

7. Petitioner was not earning substantial gainful activity as of the date of the administrative hearing.

8. Petitioner's highest education year completed was the 9th grade (via general equivalency degree).

9. Petitioner has a history of unskilled employment, with no known transferrable job skills.

10. Petitioner alleged disability based on restrictions related to diabetes mellitus (DM), hypertension (HTN), myopathy, a history of strokes, loss of visual acuity, and lumbar pain.

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 (see Exhibit 1, p. 3). FIP is a MDHHS program available to caretakers of minor children and pregnant women. Petitioner testified that she only intended to dispute a denial of SDA benefits. MDHHS was not confused by Petitioner's request to dispute FIP eligibility and was prepared to defend a denial of Petitioner's SDA application denial. It is found that Petitioner intended to dispute her 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 (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.

Hospital emergency room documents (Exhibit 1, pp. 86-95) dated [redacted], were presented. It was noted that Petitioner presented with complaints of rib pain following a fall. Petitioner reported that she fell from a height of 3-5 feet onto concrete. A normal chest x-ray was noted. X-rays of Petitioner's ribs were noted to reveal no fracture. A final diagnosis of chest wall contusion was noted.

Hospital emergency room documents (Exhibit 1, pp. 96-108) dated [redacted], were presented. It was noted that Petitioner presented with complaints of left wrist pain (7/10). It was noted Petitioner reported her wrist felt like it snapped after she tried to get up from the couch. Decreased wrist motion was noted. An x-ray of Petitioner's left wrist was noted to be normal and with no soft tissue swelling. A discharge date of [redacted] was noted.

Hospital emergency room documents (Exhibit 1, pp. 109-124) dated [redacted], were presented. It was noted that Petitioner presented with complaints of left-sided face tingling and headaches. A head CT was noted to be negative. Petitioner's coordination and gait were noted to be normal. Chest x-rays were noted to be normal. A discharge date of [redacted], was noted.

Hospital emergency room documents (Exhibit 1, pp. 125-133) dated [redacted], were presented. It was noted that Petitioner presented with complaints of a sore throat, fever, chills, and fatigue. It was noted that Petitioner received zithromax, naprosyn, and fluids. A diagnosis of pharyngitis was noted. A discharge date of [redacted], was noted.

Hospital emergency room documents (Exhibit 1, pp. 134-140) dated [redacted], were presented. It was noted Petitioner presented with a complaint of facial swelling. Diagnoses of oral infection and tooth fracture were noted.

Hospital emergency room documents (Exhibit 1, pp. 64-85) dated [redacted], were presented. It was noted that Petitioner presented with complaints of left-sided chest pain causing left-sided numbness, ongoing for 3-5 hours.

A diabetes/glaucoma screening report (Exhibit 1, p. 31) dated [redacted], was presented. It was noted Petitioner did not have glaucoma or retinopathy. An abnormality was stated (it was illegible). Petitioner's vision was noted as correctable to 20/20 in her right eye and 20/40 in her left eye.

Hospital emergency room documents (Exhibit 1, pp. 52-63) dated [redacted], were presented. It was noted that Petitioner presented with complaints of abdominal pain and nausea, ongoing for 2 days. An ultrasound of Petitioner's abdomen and lab

work were noted as performed. A diagnosis of non-specific abdominal pain was indicated.

Hospital emergency room documents (Exhibit 1, pp. 37-51) dated [redacted], were presented. It was noted that Petitioner presented with complaints of abdominal pain, ongoing for 3 days. Other noted problems included “moderate” dyspnea, coughing, and vomiting. An EKG was noted to show no acute ischemic changes. A chest x-ray was noted to show no acute cardiopulmonary process. A diagnosis of acute bronchitis was noted.

Hospital documents (Exhibit 1, pp. 70-85) dated [redacted] were presented. It was noted that Petitioner presented with complaints of chest pain (6/10), ongoing 3-5 hours. A chest x-ray was noted as without evidence of abnormality. An impression of no stress-induced ischemia was noted followings stress images of Petitioner’s left ventricle. A borderline abnormal stress EKG was noted. Petitioner’s ejection fraction was noted to be 75% (it was noted to be 57% elsewhere). Lab work was completed. A diagnosis of non-specific chest pain was noted. A discharge date of [redacted], was noted.

An internal medicine examination report (Exhibit 1, pp. 148-150) dated [redacted] was presented. The report was noted as completed by a consultative physician. Petitioner reported a history of multiple strokes, “fairly well controlled” diabetes, lumbar pain, and dizzy spells. Petitioner reported her strokes typically occur every 5 years. Petitioner reported she uses a cane and is limited to 4 hours of sleeping. A conclusion of the following was noted: HTN, DM, history of TIAs and possible CVAs, lumbar myofascitis, chronic lumbar pain, and chronic anxiety.

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 visual acuity (Listing 2.02) was considered based on complaints of poor eyesight. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Petitioner’s best eye.

A listing based on central nervous system vascular accidents (Listing 11.05) was considered based on Petitioner’s reported stroke history. The listing was rejected due to a failure to establish motor function disorganization in two extremities or ineffective speech or communication.

It is found that Petitioner does not 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 second step analysis will begin with a summary of documents that supported the original finding of disability.

A Hearing Decision (Exhibit 1, pp. 4-11) dated [redacted], was presented. The Hearing Decision indicated Petitioner was disabled. The cited support for the ALJ's decision included Petitioner's testimony, a Medical Examination Report from September 2012, and a physician letter dated [redacted].

A physician letter (Exhibit 1, p. 32) dated [redacted], was presented. It was noted Petitioner was a patient for "a few years." Petitioner was found incapable of employment due to severe disabling muscle weakness in lower extremities due to myopathy. It was noted Petitioner had significant disuse atrophy of lower extremity musculature and difficulty with balance and ambulation.

The ALJ finding disability stated Petitioner was diagnosed with diabetes, anxiety, COPD, myopathy, peripheral neuropathy, and back pain. The ALJ also indicated Petitioner's physician stated Petitioner had no right eye vision, required a cane for ambulation, had lower extremity atrophy, and degeneration problems in her lumbar. No other medical evidence was cited by the ALJ.

Presented records failed to indicate any treatment for myopathy, neuropathy, or lumbar pain. Petitioner's right eye vision apparently returned, or at least was corrected as 20/20 correctable vision was verified. Presented documents failed to verify any muscle weakness or need for a cane.

It is found Petitioner has experienced medical improvement since the finding of disability made by the ALJ. Accordingly, the analysis may proceed to the third step.

The third step of the analysis considers medical improvement and its effect on the ability to perform SGA. Medical improvement is not related to the ability to work if there has been a decrease in the severity of the impairment(s) present at the time of the most recent favorable medical decision, but *no* increase in functional capacity to do basic work activities. 20 CFR 416.994(b)(1)(ii). If there has been any medical improvement, but it is not related to the ability to do work and none of the exceptions applies, benefits will be continued. *Id*. If medical improvement is related to the ability to do work, the process moves to step five.

Presented documentation did not include physician statements that Petitioner's restrictions have lessened. Based on presented documentation, inferences of medical improvement to Petitioner's functional capacity can be made.

As noted in the second step of the analysis, a need for a cane, lower extremity weakness, and right eye blindness were absent. Petitioner had multiple hospital trips since being found disabled, however, nonre were related to the complaints supporting

the original finding of disability. Physical examination findings during the hospital trips did not note a need for a cane or lower extremity weakness.

It is found Petitioner's medical improvement relates to the ability to work. Accordingly, the analysis proceeds directly to the fifth step.

The fifth 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).

An Activities of Daily Living (Exhibit 1, pp. 20-24) dated [redacted], was presented. The form was signed by Petitioner. Petitioner listed complaints of mid-back pain, lower-back pain, and leg pain. Petitioner stated her diabetes is uncontrolled. Petitioner stated her life has been ruined by illness and that she cannot do anything she used to do.

Presented documents verified multiple hospital trips by Petitioner. Treatment for a sore throat, a chest bruise, acute wrist pain, dental infection, and undiagnosed chest pain

was verified. Numerous radiology tests were performed over Petitioner's hospital visits; presented testing was generally unremarkable. Presented hospital records were highly unpersuasive in establishing long-term problems for Petitioner.

The most compelling evidence since the finding of disability to support an ongoing disability finding was a consultative examination report. Assessments of many medical problems were noted, however, there was no stated objective medical basis to support the restrictions.

Despite underwhelming support for a claim of disability, a modicum of support was established. Based on a de minimus standard, it can be inferred (though barely) that Petitioner has some degree of lifting/carrying and/or ambulation restrictions due to her history of myopathy and back pain. Accordingly, the analysis may proceed to the sixth step.

The sixth 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 she worked as a drive-thru cashier for a fast food restaurant for 20 years. Petitioner testified she last held that job (or any other) in 2007. Petitioner testified she lost her job after she had a stroke. Petitioner testified her duties required her to lift 50 pound boxes of french fries and chicken. Petitioner testified her ongoing problems would preclude her from performing her past employment.

For purposes of this decision, Petitioner's testimony that she is unable to perform past employment will be accepted. Accordingly, the analysis may proceed to the final step.

In the seventh 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.

Physician statements of Petitioner restrictions were not presented. Restrictions can be inferred based on presented documents. The analysis will proceed to examine whether medical evidence was consistent with Petitioner's statement of restrictions.

Petitioner testimony estimated her walking is restricted to 3 blocks due to lower back pain. Petitioner testified she can stand for an indefinite period of time, as long as she holds onto something. Petitioner testified her sitting is restricted to 30 minute periods; Petitioner testified she would need to stretch for 2-5 minutes before sitting an additional 30 minutes. Petitioner testified her lifting/carrying is restricted to 10 pounds. Petitioner testimony indicated she had no problems with grooming or bathing.

Petitioner testified she always utilizes a cane to assist with ambulation. Petitioner's testimony was not verified.

Petitioner testified she recently failed a neurological examination. Petitioner's testimony was not verified.

Petitioner testified she has a herniated disc and bone spurs in her neck. Petitioner testified she has no feeling on the left side of her chest and it feels like she has pins and needles in her arms. Petitioner testified she has third stage disc disease. Petitioner presented neither back treatment records nor spinal radiology.

Petitioner testified she has recurring problems of imbalance. Petitioner testified she has a history of 9 strokes. Petitioner testified she takes baby aspirin and that she may have a blood clot. Previous stroke treatment records for strokes were not presented. Petitioner's testimony was again unsupported by presented documents.

Petitioner testified she had a recent colonoscopy (about 1 month ago) which uncovered cancerous tumors. Petitioner testimony indicated she may have to undergo radiation or surgery. Again, no treatment records supported Petitioner's testimony.

Petitioner testified her uncorrected vision is 20/200 vision in each eye. Petitioner testified she wears bifocals correcting her vision to 20/70 or 20/80. Presented documents verified a much better correction- perfect right eye vision and 20/40 left eye vision. Based on presented evidence, it is found Petitioner can perform sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (younger individual), education (less than high school but literate and able to communicate in English), employment history (unskilled), Medical-Vocational Rule 201.24 is found to apply. This rule dictates a finding that Petitioner is not disabled. Accordingly, MDHHS properly found Petitioner to be not disabled for purposes of SDA benefits. It is further found that MDHHS properly 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 properly terminated Petitioner's SDA eligibility, effective November 2015. The actions taken by MDHHS are **AFFIRMED**.

Christian Gardocki

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

Date Signed: **1/26/2016**

Date Mailed: **1/26/2016**

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]