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.: 15-020261
Issue No.: 4009
Agency Case No.: [redacted]
Hearing Date: January 6, 2016
County: Wayne (17)

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 6, 2016, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], 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 August 26, 2015, Petitioner applied for SDA benefits.

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

3. On October 13, 2015, the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 14-20).

4. On October 21, 2015, MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 10-13) informing Petitioner of the denial.

5. On October 26, 2015, Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 2-3).

6. As of the date of the administrative hearing, Petitioner was a 42-year-old male.

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

8. Petitioner's highest education year completed was the 9th grade.

9. Petitioner has a history of light-to-very heavy exertional employment, with no known transferrable job skills.

10. Petitioner alleged disability based on restrictions related to seizures and headaches.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (1/2013), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (1/2012), p. 1.A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

There was no evidence that any of the above circumstances apply to 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.

Physician office visit notes (Exhibit 1, pp. 63-64) dated August 29, 2013, were presented. It was noted Petitioner reported to establish care. A history of seizure disorder and migraine headaches was noted.

Physician office visit notes (Exhibit 1, pp. 61-62) dated September 24, 2013, were presented. It was noted Petitioner complained of recurring dizziness.

Physician office visit notes (Exhibit 1, pp. 59-60) dated October 16, 2013, were presented. It was noted Petitioner reported passing out twice in the last two weeks. It was noted Petitioner had a seizure after he ran out of medications for 2 days.

Neurologist office visit notes (Exhibit 1, pp. 89-90) dated October 22, 2013, were presented. It was noted Petitioner was evaluated for seizures. Petitioner reported having black-outs since he was 12 years old, and seizures since December 2012. Petitioner reported 4 seizures in the last 3 months. Petitioner also reported difficulty holding items with his left hand. Physical examination findings were normal. An assessment of epilepsy uncontrolled by Dilantin was noted. A plan to prescribe

Topamax was noted. Petitioner was advised to keep a log of his seizures. A 2 month follow-up was noted.

Physician office visit notes (Exhibit 1, pp. 57-58) dated November 5, 2013, were presented. It was noted Petitioner had 2 seizures when he took out his trash. It was noted Petitioner recently started taking Topamax.

Neurologist office visit notes (Exhibit 1, pp. 87-88) dated December 3, 2013, were presented. It was noted Petitioner took less Topamax than what was prescribed due to not understanding instructions. A 3 month follow-up was planned.

Physician office visit notes (Exhibit 1, pp. 55-56) dated March 19, 2014, were presented. It was noted Petitioner complained of an itchy neck rash.

Neurologist office visit notes (Exhibit 1, pp. 85-86) dated March 31, 2014, were presented. A hospital admission for breakthrough seizure treatment from January 2014 was noted. It was noted Petitioner's medications were increased and he had no seizures since the admission. Physical examination findings were normal.

Neurologist office visit notes (Exhibit 1, pp. 83-84) dated April 28, 2014, were presented. It was noted Petitioner had no seizures since his last visit. Recurring headaches (2-3 times per day) were noted as reported. Blurred vision was also reported. It was noted Petitioner had not seen an eye doctor despite a recent referral. An increase in Dilantin was noted.

Physician office visit notes (Exhibit 1, pp. 53-54) dated May 27, 2014, were presented. It was noted Petitioner reported chest discomfort (ongoing for 2 days). A recent change in seizure medications was noted. Improvement in Petitioner's neck rash was noted.

Physician office visit notes (Exhibit 1, pp. 51-52) dated July 8, 2014, were presented. It was noted Petitioner reported a possible seizure over the weekend. A change in medications was noted.

Physician office visit notes (Exhibit 1, pp. 49-50) dated September 18, 2014, were presented. It was noted Petitioner reported a headache (ongoing for 2 days) since having a seizure.

Physician office visit notes (Exhibit 1, pp. 47-48) dated October 16, 2014, were presented. It was noted Petitioner reported feeling nauseated, vomiting (ongoing for 3 days), and a recent seizure. Zofran was noted as prescribed.

Neurologist office visit notes (Exhibit 1, pp. 65-66, 81-82) dated November 3, 2014, were presented. It was noted Petitioner reported 2-3 headaches per day. Petitioner reported 7 seizures since April 2014. Vimpat was noted to be newly prescribed.

Physician office visit notes (Exhibit 1, pp. 45-46) dated November 17, 2014, were presented. It was noted a neurologist recently prescribed Vimpat for Petitioner.

Physician office visit notes (Exhibit 1, pp. 43-44) dated December 2, 2014, were presented. It was noted Petitioner complained of loose stools. A GI evaluation was noted as considered.

Neurologist office visit notes (Exhibit 1, pp. 79-80) December 2, 2014, were presented. It was noted recent EEG testing indicated normal results and no epileptiform activity.

Physician office visit notes (Exhibit 1, pp. 41-42) dated January 15, 2015, were presented. It was noted Petitioner reported a recent recurrence of diarrhea. A 4 week follow-up was noted.

Neurologist office visit notes (Exhibit 1, pp. 77-78) dated February 10, 2015, were presented. Petitioner reported a seizure after a recent slip-and-fall.

Neurologist office visit notes (Exhibit 1, pp. 75-76) dated March 17, 2015, were presented. It was noted Petitioner's Keppra dosage was increased after he was treated in the hospital following a fall on stairs. Petitioner reported a worsening of headaches since the fall. A prescription for an increased Keppra dosage was noted.

Physician office visit notes (Exhibit 1, pp. 39-40) dated March 23, 2015, were presented. It was noted Petitioner reported rectal bleeding and diarrhea. A referral to a gastrointestinologist was noted.

Physician office visit notes (Exhibit 1, pp. 37-38) dated May 7, 2015, were presented. It was noted Petitioner reported feeling occasional nausea and dizziness.

Physician office visit notes (Exhibit 1, pp. 35-36) dated May 19, 2015, were presented. It was noted Petitioner reported recent emergency room treatment for seizures. Petitioner also reported his seizures were stabilized and he was released. An increase in Dilantin was noted.

Neurologist office visit notes (Exhibit 1, pp. 73-74) dated May 21, 2015, were presented. Petitioner reported a seizure from 2 weeks earlier. It was noted Petitioner was supposed to take 2 Keppra tablets daily, but he was only taking one tablet. A 3 month follow-up was planned.

Physician office visit notes (Exhibit 1, pp. 33-34) dated June 9, 2015, were presented. It was noted that Petitioner was taking seizure medications as prescribed. It was noted Petitioner reported no recent seizures. Ongoing medications were noted to be Keppra, Topamax, and Dilantin.

Physician office visit notes (Exhibit 1, pp. 31-32) dated July 9, 2015, were presented. It was noted Petitioner reported feeling weak and dizzy, possibly from prescribed medications. Petitioner reported not having recent seizures. Assessments of dizziness, obesity, migraine headaches, seizure disorder, and BMI 39-39.9 were noted.

Petitioner testified he last had a seizure 3 days ago. Petitioner also testified he had a seizure on the day before Christmas in 2015. Neither seizure was documented in presented records.

Presented records established a 2 year minimum period where Petitioner experiences unexpected blackout-type seizures. Presented records also established Petitioner's seizures persisted despite numerous medication adjustments. A history of recurring headaches was also established. Petitioner's history of seizures and headaches was sufficiently documented to infer restrictions to Petitioner's employment opportunities and abilities.

It is found that Petitioner established significant impairment to basic work activities for a period longer than 90 days. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

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.

Petitioner's most prominent impairment appears to be ongoing seizures. SSA provides two different listings related to epilepsy; the listing read as follows:

> **11.02 Epilepsy** - convulsive epilepsy, (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment. With:
>
> A. Daytime episodes (loss of consciousness and convulsive seizures) or
>
> B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.
>
> **11.03 Epilepsy -** nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern including all associated phenomena, occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

Petitioner did not present a detailed description of a typical seizure pattern. Without such documentation, a consideration for epilepsy listings should not be undertaken. Despite the failure, conclusions can be drawn from Petitioner's testimony and medical documentation.

Petitioner testified a seizure typically knocks him out for 5-10 minutes; such loss of consciousness is consistent with a grand mal seizure. Despite Petitioner's testimony, none of Petitioner's seizures were documented as a grand mal seizure. Medical evidence was insufficient to conclude Petitioner meets the listing for epilepsy with convulsive seizures.

Petitioner's testimony conceded he has seizures less frequently than every week. Petitioner estimated he had 14 seizures in 2015, an average close to once a month. Petitioner also testified his seizures typically occur every two weeks which is also below the 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 had previous full-time employment working at a gun parts factory, painting machine plates, and as a press operator/hi-lo driver/welder. Petitioner's testimony indicated all of his previous work involved some type of machine usage. Given petitioner's seizures, it would be dangerous for Petitioner to attempt any type of work involving machines.

It is found Petitioner is unable to return to perform past full-time employment. Accordingly, the analysis may proceed to the final step.

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.

Presented documents verified a history of seizures and headaches. Presented documents also demonstrated a recurrence of seizures despite neurologist treatment and medication adjustments. Petitioner testified he sometimes "can't move for days at a time" due to headaches. Petitioner's testimony could be construed to prevent the performance of any employment.

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

It is notable that some of Petitioner's seizures were caused by medication noncompliance. It is appreciated that the noncompliance appeared to be unintentional, however, the evidence was suggestive that Petitioner's seizures are somewhat controllable.

It is notable that Petitioner testified he was 5'10" and weighed 281 pounds. Petitioner's BMI would be approximately 40. Petitioner testimony conceded his physician advised him that his obesity may be a primary cause of ongoing seizures and/or headaches. Petitioner has not demonstrated any inclination to follow the advice to lose weight.

It is also notable that there was not any particular evidence linking Petitioner's complaint of headaches to the seizures. Petitioner's complaint of headaches was documented by his neurologist, but his neurologist made no particular statement of correlation between the headaches and seizures. If radiology had verified some brain abnormality, a correlation may have been justified; no radiology was presented.

Petitioner's seizure history would justify finding that Petitioner could not perform employment involving heights, near open water, driving, chemicals, and heavy machinery. Preclusion from such employment would erode Petitioner's sedentary base, but not enough to justify that ample employment opportunities do not exist for Petitioner. Petitioner could perform jobs such as clerical, telemarketing, light assembly, and retail. MDHHS did not present evidence of the availability of such jobs but it is presumed that they are available in sufficient supply so that a finding of non-disability is warranted.

Petitioner's headaches if accepted to be a significant impairment would prevent the performance of complex employment (e.g. accounting, teaching…). The above-listed jobs available to Petitioner are relatively non-complex and deemed to be within Petitioner's medical capabilities. Petitioner testimony expressed skepticism that he had the education to perform office-type work; this consideration is irrelevant to the analysis except in factoring Petitioner's education within the vocational grid.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 18-44), 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, it is found that MDHHS properly found Petitioner to be not disabled for purposes of SDA benefits.

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 August 26, 2015, 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: **1/13/2016**

Date Mailed: **1/13/2016**

CG/tm

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

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

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

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

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

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

Attention: MAHS Rehearing/Reconsideration Request

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

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

cc: [redacted]