RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

DATE MAILED: MARCh 4, 2016
MAHS DOCKET NO.: 15-020762
AGENCY NO.: [redacted]
PETITIONER: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, an in person hearing was held on January 4, 2016, from Madison Heights, Michigan. The Petitioner was represented by the Petitioner. The Department of Health and Human Services (Department) was represented by [redacted], Family Independence Manager (FIM).

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional medical records. The documents were received. The record closed on February 3, 2016; and the matter is now before the undersigned for a final determination.

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 recipient of SDA benefits.

2. On [redacted], the Medical Review Team (MRT) issued a Medical Social Eligibility Certification which form was not completed as regards the medical evidence considered and determined that the Petitioner was no longer eligible for SDA as he was capable of other work and the physical or mental impairment

would not prevent employment of 90 days or more. (Exhibit A, pp. 11-18). The MRT examiner evaluated the case based upon alleged disabilities of Grave's disease, Coronary Artery Disease, and Multiple Sclerosis. (Exhibit A, p. 18).

3. The MRT analysis apparently relied on an examination by the Petitioner's neurologist dated [redacted], and a Medical Examination Report dated [redacted], by the Petitioner's cardiologist.

4. On [redacted], the Department sent Petitioner a Notice of Case Action notifying him that his SDA case would close effective December 1, 2015, because MRT had denied the Petitioner's claim (Exhibit A, pp. 5-6).

5. The Petitioner requested a timely hearing on November 12, 2015.

6. Petitioner's application with the Social Security Administration (SSA) continued to be pending on appeal as of the hearing date.

7. Petitioner alleged physical disabling impairment due to multiple sclerosis, Graves Disease, syncope and dizziness with seizure disorder, (spells), Coronary Artery Disease and chest pain.

8. The Petitioner did not allege any Mental Disabling Impairment.

9. At the time of hearing, Petitioner was [redacted] years old with a [redacted], birth date; he was 5'7" in height and weighed 195 pounds.

10. At the time of the hearing, the Petitioner had established a medical need for Home Help Services, which were approved and which services were being provided to assist Petitioner with activities of daily living.

11. A Hearing Decision, Reg. No. 2013-49988, was issued on November 28, 2013, which Ordered the Department review the Petitioner's case in November 2014. No such review was made until July 2015.

12. The Petitioner completed the 11th Grade and obtained a GED. The Petitioner has no relevant work history for the last [redacted] years.

13. The Petitioner's physical impairments have lasted and will continue to last for 90 days or more.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

A disabled person is eligible for SDA. BEM 261 (July 2014), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment lasting, or expected to last, at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Once an individual has been found disabled, continued entitlement to benefits based on a disability 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(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an 8 step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in substantial gainful activity. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA after 2009 and at any time since he became eligible for SDA. Therefore, his disability must be assessed to determine whether it continues. The eight steps for reviewing whether a disability continues are as follows:

> **Step 1.** Does the individual have an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404? If so, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If not, has there been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 If there has been medical improvement as shown by a decrease in medical severity, go to Step 3. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies.
>
> **Step 3.** If there has been medical improvement, is it related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i)

through (b)(1)(iv); *i.e.*, was there an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination? If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5.

Step 4. If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

Step **5.** If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled.

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended.

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues.

Step 8. Step 8 may apply if the evidence in the individual's file is

> insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work.

Step One

Step 1 in determining whether an individual's disability has ended 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 with no further analysis required.

In order to determine whether the Petitioner meets a listing, the available medical evidence must be reviewed. The Petitioner alleges physical disabling impairments which include relapsing Multiple Sclerosis, Coronary Artery Disease (CAD) with ongoing chest pain, Graves Disease and syncope and dizziness with spells. A summary of the medical evidence follows.

The Petitioner was seen by his treating doctor of internal medicine on [redacted], when a Medical Examination Report was completed. At the time, the Petitioner was assessed limitations were imposed. The Petitioner could lift less than 10 pounds occasionally. He could stand and or walk less than 2 hours in an 8-hour workday. The Petitioner was noted as should not sit more than 2 hour a day. The findings supporting the limitations were noted that Multiple Sclerosis causes episodes of extremity weakness, loss of strength and episodes of falling. The Petitioner was noted as requiring assistance with activities of daily living including food preparation, home cleaning. An earlier assessment in [redacted] noted several seizure-like episodes at the time; and the doctor noted some kidney insufficiency, which could be related to medications, and noted Stage 3 renal disease with possible referral to nephrologist.

The Petitioner's cardiologist completed a Medical Examination Report on [redacted], [redacted] The report imposed limitations and noted Dyspnea and chest pain with mild activity. On examination, the doctor notes chest pain, heaviness, CAD, angina, Dyspnea with mild activity and syncope. The basis for the limitations imposed were due to Dypsnea and chest pain with mild activity. The Doctor did not complete the charts completely to express what limitations were present. The report also noted abnormal stress test and that patient was advised to schedule a follow-up. The Petitioner was also referred to see EP physician in [redacted] for syncope reported. A prior Medical Exam Report dated [redacted], found no limitations but noted that the Petitioner had chest pain, CAD 50% RCA and MLAD 70% on catheterization. It also noted unstable angina and that a stress test was ordered but no results were available

when the report was completed. (See abnormal stress test results below). Also notes chest heaviness resolves with rest and that complaints of dypsnea was referred to a pulmonary doctor.

A Medical Examination Report was completed by the Petitioner's treating neurologist on [redacted], with a current diagnosis of multiple sclerosis/spells. The doctor provided MRI and EEF reports. The report noted hyper reflex and lower left extremity. The report noted anxious and slowed processing of mental process. The Petitioner was stable, and limitations were imposed. The evaluation noted the patient could lift occasionally 10 pounds and frequently lift 25 to 50 pounds, which appears inconsistent and thus, cannot be used. (See prior Medical Exam Report [redacted]). The patient could not use his feet or legs to operate foot/leg controls and could not reach or push/pull with either hand/arm. The Petitioner could meet his needs in the home. The findings supporting limitations were gait and lower extremity spasms.

A prior Medical Examination Report available to the MRT was completed on [redacted] by the Petitioner's neurologist. The report noted limitations based upon a diagnosis of Multiple Sclerosis and spells. The Medical exam of systems was normal and the impression was Petitioner was stable. The Petitioner was limited to lifting frequently less than 10 pounds frequently and occasionally 10 to 20 pounds; Petitioner could stand and or walk less than 2 hours in an 8-hour workday, sit less than 6 hours in an 8-hour workday and assistive devices were required for ambulation. The Petitioner was restricted from using either hand/arm for pushing/pulling and reaching and operating foot controls. The Doctor also noted mental observations that Petitioner had limitations in comprehension, memory and sustained concentration. The doctor found that the Petitioner could not meet his needs in the home and found he needed assistance with meal preparation, mobility, dressing and bathing, medication and laundry and housework.

The Petitioner underwent a Stress test on [redacted]. The Patient was able to achieve 82% of his PMHR and a 9 MET workload. The Impression noted Symptomatic submaximal stress test, which is positive diagnostic ST segment shifts. The SPECT MPI is within normal limits. There are no clear-cut fixed or reversible perfusion defects noted. Gated images show normal wall motion and normal wall thickening. The ejection fraction is estimated to be 70%. The left ventricle appears to be somewhat more dilated on the post stress images. Note that the scenario of symptomatic stress test with exercise induced ECG abnormalities and normal myocardial perfusion may be seen in patients with "balanced" CAD. The study was terminated due to chest discomfort, treadmill score is (-7) indicative of intermediate cardiovascular risk. The test was terminated due to fatigue, Dyspnea and chest discomfort. Peak heart rate was 141; predicted Max heart rate 171. Fitness rating for age of patient was average.

The Petitioner was seen on [redacted] by a referral of his cardiologist to an endocrinologist who assessed Petitioner's Graves Disease. The notes indicate that a diagnosis of hyperthyroidism was made which had existed for 10 years. A referral to

nuclear medicine was made. The patient will be receiving nuclear therapy for Graves disease and after treatment will require replacement therapy for rest of his life.

A CT of the pelvis was performed on [redacted], and resulted in a normal review, noting no acute abnormality identified in pelvis and noted spondylolysis posterior elements of L5 without significant spondylolisthesis. A chest PA/AP was performed [redacted], with normal results for age.

The Petitioner was seen by his neurologist on [redacted]; at which time, he was diagnosed with Demyelinating Disease of central nervous system and spells. The exam was for a neurological reassessment. At the time of the exam, the Petitioner noted two additional syncopal events. The notes indicate that the Patient has relapsing Multiple Sclerosis. The notes indicate that the current symptoms of fatigue, imbalance and discoordinated are not new or different. The doctor's analysis notes differential diagnosis includes: atypical presentation of seizure - less likely at this time. Global cerebral hypoperfusion on a cardiac, vagal, or other systemic medical basis. Primary psychogenic entity would appear to be less likely. Patient also has Demyelinating Disease, with chronic lower extremity weakness, imbalance, fatigue and cognitive slowing. There also is a superimposed psychophysiologic component to symptoms. In October, patient reports two to three events with lightheadedness, dizziness and faints. Patient reported falling to ground and briefly lost consciousness.

On [redacted], the Petitioner was seen for follow-up neurological treatment. At that time, spells had reduced with no seizure since last visit but continues to have foggy headedness and imbalance. The patient reported fatigue, shortness of breath and lack of energy with exertion and at rest. The Multiple Sclerosis was stable at the time of the exam. At the exam, drug options were discussed; and a decision to try Aubagio with negative side effects, including liver damage, compromising immune system, and hair thinning.

On [redacted], the Petitioner was seen for a reassessment neurologic review. At the exam, the Petitioner reported that he took himself off Dilantin without starting Lamictal, because his insurance company did not approve Lamictal. Reported stiffening jerking seizure that morning. The report noted weakness in the arms and legs and imbalance, but no falling. The Assessment noted underlying spells consistent with seizure and pseudoseizure. Most recent episode was due to being off Dilantin without starting Lamictal. He has relapsing remitting multiple sclerosis with chronic extremity weakness, imbalance and fatigue. Superimposed upon this is underlying endocrine and cardiac disease. At that time the doctor indicated that due to his numerous conditions Petitioner needed help with cooking, cleaning, heavy lifting and household maintenance.

Petitioner was seen for neurologic reassessment on [redacted]. At the exam, the patient had migraine headache, which occur intermittently. At the time, there were

no episodes of spells. At the time of exam, Multiple Sclerosis was stable and cardiac was stable.

A [redacted], neurological reassessment note positive oligoclonal bands, which indicate multiple sclerosis. At the time, medications were not changed due to ongoing cardiac problems.

The Petitioner was first seen by the neurologist in [redacted]; at which time, the assessments were spells and ataxic gait. The doctor ordered tests for an EEG and MRI of the brain as well as cervical spine.

An MRI of the cervical spine was performed on [redacted]. The Impression was mild multilevel cervical degenerative change no central stenosis or cord signal abnormality.

An MRI of the brain was performed on [redacted]. The impression was bilateral foci of periventricular and hemispheric white matter lesions including the corpus callosum. Primary differential consideration is a demyelinating process. Inflammatory or prior infections process would also be considered radiographically. No enhancing lesions or diffusion signal abnormality.

An Echocardiogram was performed on [redacted]. Left ventricle was normal as was ejection fraction. There was no aortic valve stenosis or regurgitation present. The Mitral valve had a trace of mitral regurgitation. The left ventricular filling pattern is consistent with elevated mean left atrial pressure. There was a trace tricuspid valve regurgitation. There was a trace pulmonic regurgitation. There was no pericardial effusion, vena cava normal size and no dilation of aortic root.

A lumbar puncture was performed to obtain CSF fluid for evaluation for Multiple Sclerosis, on [redacted].

On [redacted] an angiography, left heart catheterization, left ventiruclography with ejection fraction of 65% and FFR, LAD and right coronary artery. The Left anterior descending artery had a long 50% lesion and ostial 30% stenosis. Right coronary artery had 50% lesion. After the procedure, the recommendations were ongoing medical therapy with statin and aspirin. The impression was two vessel nonobstructive Coronary Artery Disease.

A CTA of the heart was perform on [redacted], due to chest pain. The findings noted the Left main coronary artery was normal showing no evidence of CAD. The LAD system is diffusely with both calcified and mixed plaque the most severe of which is in the 25-50% stenosis range. The left circumflex artery was normal. Right coronary Artery noted proximal segment has mixed plaque in the 70% stenosis range with the remainder normal. Posterior descending artery and posterior lateral branch were normal. The aorta, pericardium, cardiac chamber and aortic and mitral valves were all

normal. Impression was mild dependent subsegmental pulmonary atelectiasis. The impression was abnormal coronary arteries severe mixed plaque in the proximal RCA; diffuse mild to moderate plaque in proximal LAD.

The Petitioner was seen at the hospital on [redacted], for headache and was released with medication.

The Petitioner was admitted on [redacted], through [redacted], due to heart problems and chest pain. At the time of admission, the Petitioner had taken two nitro pills with little relief. The patient arrived by ambulance. The Petitioner after testing was released and was stable.

The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Listing 4.04 Ischemic Heart Disease, with respect to Coronary Artery Disease was reviewed and the required Angiographic evidence presented above do not meet the required findings as the testing demonstrated non obstructive Coronary Artery Disease. Listing 11.09 Multiple Sclerosis was also reviewed as was Listing 11.03 for Epilepsy. The medical evidence presented regarding the Petitioner's Multiple Sclerosis did not demonstrate the required disorganization of a motor function with substantial muscle weakness on repetitive activity. Likewise the Petitioner's seizures have subsided with medication and epilepsy was not diagnosed, and thus the epilepsy Listing is not met. Listing 9.02 Thyroid Disorders was also considered however the objective medical evidence did not demonstrate any thyroid related changes in blood pressure and heart rate causing arrhythmias or other cardiac dysfunction nor was there thyroid related weight loss.

Step Two

If the impairment(s) does not meet or equal a Listing under Step 1, then Step 2 requires a determination of whether there has been medical improvement as defined in 20 CFR 416.994(b)(1). 20 CFR 416.994(b)(5)(ii). If there is medical improvement, the analysis proceeds to Step 3. If there is no medical improvement, the analysis proceeds to Step 4. **20 CFR**.

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). If no medical improvement found, and none of the exceptions listed below in Step 4 applies, then an individual's disability is found to continue.

In this case, the Petitioner had been initially approved for SDA by a Hearing Decision by the undersigned issued on [redacted], finding the Petitioner disabled at Step 5 based upon a treating doctors' evaluation placing the Petition at less than sedentary. The MRT in its current Medical Certification does not clearly identify what medical evidence was relied upon in the finding that Petitioner was not disabled, but it does

appear that one of the Medical examination reports from a treating physician indicates that due to Petitioner's multiple conditions, his treating Doctor of Internal Medicine found him less than sedentary and indicated that Petitioner had a need for help with some activities of daily living. The Petitioner was first found disabled for SDA purposes in November 2013 and a review was ordered for November 2014. No such review occurred until October 2015, two years after the initial determination of disability and approval for SDA. In addition, the MRT review noted a credibility finding, finding the Petitioner not credible but did not specify what specific statements or complaints of the Petitioner were not credible. In addition, the MRT did not interview the Petitioner in person; thus, its conclusions are not considered supported by evidence in the record.

A review of the medical evidence presented fails to establish any medical improvement in Petitioner's condition over the course of the last two years. To the contrary, the objective medical evidence shows that the while the Petitioner's coronary medical conditions are stable, the Petitioner continues to have chest pain with stenting and recently had an abnormal stress test requiring follow up. The Multiple Sclerosis is relapsing and re-occuring. A finding that the Petitioner is stable does not translate to medical improvement. The objective evidence based upon a brain MRI and testing indicated positive oligoclonal bands and brain lesions. He has been diagnosed by his treating neurologist in [redacted] with demyelinating disease with chronic lower extremity weakness, imbalance, fatigue and cognitive slowing. His treating internal medicine doctor continues to find him less than sedentary and finds he needs assistance with activities of daily living. Lastly, most recently the Petitioner's Graves Disease needed treatment with nuclear medicine. The Petitioner himself presented at the hearing using a walker. He testified that he currently has assistance with showering, meal preparation, household cleaning and laundry. Petitioner also credibly testified that his legs are weak and he experiences weakness and occasional falling. Petitioner's treating internal medicine doctor has also suggested a referral to a nephrologist due to kidney dysfunction and recent urination of blood with a note assessing the Petitioner with Stage 3 renal disease. The opinions and evaluations of the treating physicians were relied upon and given deference as they were supported by the objective medical evidence and testing.

After a thorough review of the medical evidence relied upon in the earlier finding that Petitioner was disabled in 2013, the Department has failed to substantiate a decrease in the medical severity of the impairment(s) which was present at the time of the most unfavorable medical decision by MRT. Thus, the evidence does not support a finding that there was a medical improvement in Petitioner's condition.

Step Four

When there is no medical improvement, an assessment of whether one of the exceptions in 20 CFR 416.994(b)(5)(iv) applies is required. If no exception is applicable, disability is found to continue. *Id.*

The first group of exceptions to medical improvement (i.e., when disability can be found to have ended even though medical improvement has not occurred) found in 20 CFR 416.994(b)(3) are as follows:

(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.

There was no evidence presented at the hearing that any of the exceptions contained in sub paragraphs (i) through (iv) applied in this case. Thus, the Department did not present any evidence establishing that, from the date of review to the date of hearing, an exception under the first set of exceptions to medical improvement applied to Petitioner's situation.

The second group of exceptions to medical improvement are found in 20 CFR 416.994(b)(4) and are as follows:

(i) A prior determination was fraudulently obtained;
(ii) The individual failed to cooperated;
(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.

If an exception from the second group listed above is applicable, a determination that the individual's disability has ended is made. 20 CFR 416.994(b)(5)(iv).

In this case, the Department has failed to establish that any of the listed exceptions in the second group of exceptions to medical improvement apply. Although MRT concluded in the DHS-49A that Petitioner was no longer disabled and made a credibility determination there was no evidence presented in the medical file that Petitioner was referred to, or failed to follow, any prescribed treatment that was expected to restore his ability to engage in substantial gainful activity**.**

Because the evidence presented does not show a medical improvement and no exception under either group of exceptions at Step 4 applies, the Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner has continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's

SDA eligibility continues; and the Department did not act in accordance with Department policy when it closed his SDA case.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

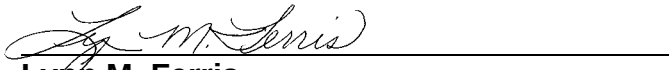
THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. The Department shall reinstate the Petitioner's SDA case effective from the date of closure December 1, 2015;

2. Issue supplements to Petitioner for any lost SDA benefits that he was entitled to receive from December 1, 2015, ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in March 2017 in accordance with Department policy.



LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

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

DHHS [redacted]

PETITIONER [redacted]