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.:	15-021338
Issue No.:	4009
Agency Case No.:	[redacted]
Hearing Date:	January 19, 2016
County:	Wayne-District 57 (Conner)

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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, a telephone hearing was held on January 19, 2016, from Detroit, Michigan. Petitioner appeared and represented himself. The Department was represented by [redacted], Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner submitted medical examination reports completed by his electrophysiologist, orthopedic doctor, and primary care physician that were admitted into evidence as Exhibits 2, 3 and 4, respectively. The October 2015 hospitalization records and December 28, 2015 cervical spine MRI report requested from the Department were NOT received. The record closed on February 18, 2016, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

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 July 8, 2015, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On October 14, 2015, the Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 1-9).

3. On October 30, 2015, the Department received Petitioner's timely written request for hearing.

4. Petitioner alleged disabling impairment due to degenerative disc disease (DDD), hypertension (HTN), atrial fibrillation (afib), and depression.

5. On the date of the hearing, Petitioner was [redacted] years old with a [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

6. Petitioner completed the [redacted] grade and received a [redacted] He can read, write, and do basic math.

7. Petitioner has an employment history of work as a roofer and as a warehouse worker at a roofing supply distribution company.

8. At the time of application, Petitioner was not employed.

9. Petitioner has a pending disability claim with the Social Security Administration (Exhibit 1).

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 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 disabled person is eligible for SDA. BEM 261 (July 2015), 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 for 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).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility 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, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. 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). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner has not engaged in SGA activity during the period for which assistance might be available. Therefore, Petitioner is not ineligible under Step 1 and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

In the present case, Petitioner alleges disabling impairment due to DDD, HTN, afib, and depression. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

Petitioner's records include notes from office visits to his primary care physician (Exhibit A, pp. 33-37). Notes from the June 24, 2014 office visit showed that Petitioner had paroxysmal afib, almost persistent, with an episode of afib a month ago following a chemical cardioversion. The notes indicated that Petitioner was being treated with metoprolol with no significant recurrence; his HTN was not well-controlled and he was advised to comply with his medication and to exercise and eat a low-salt diet. He was counseled on tobacco cessation. (Exhibit A, pp. 35-37.)

On April 24, 2015, Petitioner underwent an initial psychosocial assessment by a LLMSW, PhD at the [redacted] after reporting concerns of sadness, loss of interest, irritability, crying spells, racing thoughts, trouble sleeping, social withdrawal, mood swings, trouble concentrating, some hypervigilant behaviors, feeling down, and anxiousness. He reported no audio or visual hallucinations and having suicidal thoughts in September 2014 resulting in taking 5 Xanax pills in a suicide attempt but denied current suicidal/homicidal thoughts. He was found to have appropriate affect and mood; to be oriented to space, time and location; to have no symptoms of psychosis; to have coherent thought process; normal tone and volume speech; and fair eye contact. He answered questions appropriately. His insight, judgment and memory were intact. He reported using crack, alcohol, marijuana, and heroin but being clean 15 days. He was diagnosed with major depressive disorder, recurrent, severe with psychotic features and substance dependence. He was assigned a global assessment of functioning (GAF) score of 55. His prognosis was poor. (Exhibit A, pp. 19-23.) Transfer/discharge summary and interim person-centered plan documents completed April 15, 2015 show a diagnosis of major depressive disorder, single episode, moderate (Exhibit A, pp. 17-18, 50-51). Petitioner participated in bimonthly counseling between May 15, 2015 and July 1, 2015. Notes from counseling sessions show a diagnosis of major depressive disorder, recurrent, severe without psychotic features (Exhibit A, pp. 14-18.)

A May 15, 2015 lumbar spine MRI showed advanced disc degenerative disease with marginal osteophytes and bulges at multiple levels with a combination of disc bulge and facet arthropathy resulting in mild spinal canal stenosis at L3-L4 and L4-L5; asymmetric hypertrophic arthropathy resulting in significant bilateral neural foraminal stenosis throughout the lumbar spine; and no discrete bony pathology or abnormal enhancement (Exhibit A, pp. 44-45).

On July 8, 2015, Petitioner's primary care physician wrote a letter for disability purposes explaining that Petitioner had multiple medical problems, the most severe being DDD with spinal stenosis which caused chronic pain, paresthesias, and an inability to walk without assistance (Exhibit A, p. 47).

On July 15, 2015, Petitioner's primary care physician, who had treated Petitioner for five years, completed a medical examination report, DHS-49, identifying Petitioner's diagnoses as HTN, lumbar back pain, afib, and DDD. In her physical examination of Petitioner, the doctor did not note any abnormalities other than his left lower extremities being weaker (4/5) than his right lower extremities (5/5) and lumbar pain measuring 8/10. The doctor noted that Petitioner's condition was stable and identified the following limitations: (i) he could frequently lift and carry up to 10 pounds, occasionally lift and carry 20 pounds, and never 25 pounds or more; (ii) he could use both hands/arms to grasp, reach and fine manipulate but neither to push or pull; (iii) he could not use his left foot or leg to operate foot and leg controls; (iv) he could sit about 6 hours in an 8-hour workday. (Exhibit A, pp. 63-65.)

On September 29, 2015, Petitioner was examined by a licensed psychologist at the Department's request. Based on his responses to questions and records from [redacted] dated April 2015 diagnosing Petitioner with major depressive disorder, single episode, moderate, the psychologist diagnosed Petitioner with adjustment disorder with mixed emotional features and found that his prognosis was fair. The psychologist noted that, in light of his difficulty performing calculation tasks, Petitioner was not capable of managing his own benefit funds. The psychologist concluded as follows:

> Based on today's examination, [Petitioner] demonstrated difficulties with concentration as evidenced by performance on calculation tasks. He displayed relatively impaired fund of general information as well. He would appear to have difficulty engaging successfully in work type activities other than those of an extremely simple repetitive type, best suited to a two or three step procedure with little to no independent judgment or decision making required.

(Exhibit A, pp. 10-13.)

On January 27, 2016, Petitioner's electrophysiologist completed a medical examination report, DHS-49, listing Petitioner's diagnoses as premature ventricular complex (PVC),

palpitations, and history of afib. The doctor found no abnormalities in his physical examination of Petitioner's respiratory or cardiovascular systems. Relying on the physical exam and a November 4, 2015 Holter electrocardiogram report and December 8, 2015 cardiac monitoring report, the doctor indicated that Petitioner's condition was stable and improving and that Petitioner had no physical limitations. (Exhibit 2.)

On February 3, 2016, Petitioner's orthopedic doctor completed a DHS-49 listing Petitioner's diagnoses as lumbar stenosis L3-5, referencing an MRI that showed foraminal stenosis. In examining Petitioner's musculoskeletal system, the doctor noted a positive straight leg raise; tenderness to palpitation at L3-5; and muscle strength of 4/5 of the left hip, knee and ankle. The doctor concluded that Petitioner's condition was stable and identified the following limitations: (i) he could frequently lift and carry 10 pounds and never more; (ii) he could stand and/or walk less than 2 hours in an 8-hour workday; and (iii) he could not operate foot or leg controls with either foot or leg. The doctor did not identify any restrictions to Petitioner's sitting or use of his hands and arms. He did not find that Petitioner needed an assistive device for ambulation. (Exhibit 3)

On February 4, 2016, Petitioner's primary care physician completed a second DHS-49 listing Petitioner's diagnoses as HTN, DDD of the lumbar spine and cervical spine with foraminal stenosis, and afib. In his physical examination of Petitioner, the doctor noted that Petitioner had a slow gait, limited flexion at the waist, a negative straight leg raise, and muscle strength 5/5 throughout. The doctor commented that Petitioner had DDD and some spinal stenosis that resulted in back pain and paresthesia. The doctor concluded that Petitioner's condition was stable and identified the following limitations: (i) he could frequently lift and carry up to 10 pounds, occasionally lift and carry 10 and 20 pounds, and never lift and carry 25 pounds or more; (ii) he could stand and/or walk less than 2 hours in an 8-hour workday; (iii) he could use both arms and hands to grasp and manipulate but neither arm or hand to push or pull. The doctor did not identify any sitting restriction or limitations in Petitioner's use of his feet or legs. (Exhibit 3.)

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.04 (disorders of the spine), 4.02 (chronic heart failure), 4.05 (recurrent arrhythmias), and 12.04 (affective disorders) were considered. A listing under 1.04 requires evidence of nerve root compression, spinal arachnoiditis, or lumbar spinal stenosis resulting in pseudoclaudication established by findings on appropriate medically acceptable imaging and resulting in an inability to ambulate effectively. A listing under 4.02 requires medically documented presence of either systolic failure or diastolic failure. A listing under 4.05 requires uncontrolled, recurrent episodes of cardiac syncope or near syncope despite prescribed treatment. A listing under 12.04 requires either (i) medically documented persistence of depressive, manic, or bipolar syndrome resulting in marked limitations in functioning or (ii) medically documented history of a chronic affective disorder of at least two years' duration that has caused more than a minimal limitation of ability to do basic work activities with either repeated episodes of decompensation, residual disease process, or one or more years' current inability to function outside a highly supportive living arrangement.

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. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b). The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket

files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the 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. 20 CFR 416.967(b). 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). 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). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions 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 (i.e., unable to 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). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his impairments. Petitioner testified that he suffered from excruciating sharp, constant lower back pain that shot down his leg and neck pain from his left shoulder. He could walk a block with a cane, sit no more than 45 minutes but up to three hours at home, and stand no more than 25 minutes. He could grip items but could not lift more than 10 pounds. He lived with his mother. He was usually able to take care of his personal hygiene but sometimes relied on his mother to assist him. He could dress himself but used a claw or his mother's assistance to put on his socks. He did none of the household chores, counting on his mother or sister who lived next door to do them. He could shop and believed he could drive if he had a license. He had no hobbies but got together with family. He testified he had last used alcohol in May 2015.

The May 15, 2015 lumbar spine MRI showed advanced DDD with disc bulges at multiple levels and mild spinal canal stenosis at L3-L4 and L4-L5 and significant bilateral neural foraminal stenosis throughout the lumbar spine, supporting Petitioner's complaints of back pain. Petitioner's primary care physician also supported Petitioner's complaints of back pain and identified the following limitations: (i) he could frequently lift

and carry up to 10 pounds, occasionally lift and carry 20 pounds, and never 25 pounds or more; (ii) he could use both hands/arms to grasp, reach and manipulate but neither to push or pull; (iii) he could not use his left foot or leg to operate foot and leg controls; (iv) he could sit about 6 hours in an 8-hour workday. In the DHS-49 he completed on February 3, 2016, Petitioner's orthopedic doctor also supported Petitioner's back pain, finding that Petitioner had a positive straight leg raise, tenderness to palpitation at L3-5, and muscle strength of 4/5 of the left hip, knee and ankle and identified the following limitations: (i) he could frequently lift and carry 10 pounds, and never more; (ii) he could stand and/or walk less than 2 hours in an 8-hour workday; and (iii) he could not operate foot or leg controls with either foot or leg. Petitioner's orthopedic doctor did not identify any sitting restrictions or restrictions concerning Petitioner's use of his hands and arms and did not find that Petitioner needed an assistive device for ambulation.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a). Although Petitioner also alleged limitations due to his afib, his electrophysiologist found no abnormalities in his physical examination of Petitioner's respiratory or cardiovascular systems and, relying on the physical exam, a November 4, 2015 Holter electrocardiogram report and December 8, 2015 cardiac monitoring report, the doctor indicated that Petitioner's condition was stable and improving and that Petitioner had no physical limitations due to his cardiac condition.

Petitioner also alleged nonexertional limitations due to his mental condition, testifying that he was depressed because of his physical and financial situation and saw a therapist once a month at [redacted]. In the September 29, 2015 mental status examination of Petitioner, the independent psychologist found that Petitioner had difficulties with concentration and had a relatively impaired fund of general information. He concluded that Petitioner had an adjustment disorder and would have difficulty with work activities other than those of a simple, repetitive nature involving not more than two- or three-step procedures with little to no independent judgement or decision-making required. The April 24, 2015 initial psychosocial assessment at [redacted] diagnosed Petitioner with major depressive disorder with a GAF score of 55. He was found to have appropriate affect and mood; to have no symptoms of psychosis; to have coherent thought process; and intact insight, judgment and memory. Based on the medical record presented, as well as Petitioner's testimony, Petitioner's nonexertional RFC limits him to performing simple, repetitive activities.

Petitioner's RFC is considered at both steps four and five. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has

the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a roofer and a warehouse worker at a roofing supply distribution center. Based on the standing and lifting requirements of those two occupations, Petitioner's prior involvement involved heavy work. Based on the RFC analysis above, Petitioner is limited to no more than sedentary work activities. In light of Petitioner's exertional RFC, Petitioner is incapable of performing past relevant work. Accordingly, Petitioner cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step 5

In Step 5, an assessment of Petitioner's RFC and age, education, and work experience is considered to determine whether an adjustment to other work can be made. 20 CFR 416.920(4)(v). If the individual can adjust to other work, then there is no disability. Disability is found if an individual is unable to adjust to other work.

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, 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). However, 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). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination unless there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing and, thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He has a GED and a history of semi-skilled work experience, with non-transferable skills. As discussed above, Petitioner maintains the RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities and, because of his nonexertional RFC, is limited to simple, repetitive activities. In this case, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled, 201.21, based on exertional limitations. Because

Petitioner can engage in simple, repetitive tasks, his mental RFC does not affect his ability to perform the non-exertional aspects of work-related activities.

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 **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

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

Alice C. Elkin
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **3/8/2016**

Date Mailed: **3/8/2016**

ACE / tlf

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]