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: May 6, 2016
MAHS Docket No.: 16-002716
Agency No.: [redacted]
Petitioner: [redacted]

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, an in-person hearing was held on April 18, 2016, from Detroit, Michigan. Petitioner appeared and was represented by [redacted] case manager with [redacted]. 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 [redacted], Petitioner applied for SDA benefits.
2. Petitioner's only basis for SDA benefits was as a disabled individual.
3. On [redacted], the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 2-7).
4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, p. 1).

6. As of the date of the administrative hearing, Petitioner was a 52-year-old male.

7. As of the date of the administrative hearing, Petitioner did not have employment earnings amounting to substantial gainful activity.

8. Petitioner's highest education year completed was the 10th grade.

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

10. Petitioner alleged disability based on restrictions related to mental health problems, arm dysfunction, and cardiac problems.

CONCLUSIONS OF LAW

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

Petitioner requested a hearing to dispute the denial of a SDA application. It was not disputed that MDHHS denied Petitioner's application due to Petitioner's failure to meet disability requirements.

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. Accordingly, the disability analysis may proceed to the second step.

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.

Hospital emergency room documents (Exhibit A, pp. 326-330) dated [redacted], were presented. It was noted that Petitioner presented with complaints of a "funny feeling" in his chest. Chest radiology was noted to be negative. An impression of low-risk chest pain, with diabetes and HTN was noted.

Hospital emergency room documents (Exhibit A, pp. 331-338) dated [redacted], were presented. A complaint of recurring chest pain was noted. Petitioner reported pain improved with exertion. Petitioner reported running out of medications. An impression of angina was noted.

Hospital emergency room documents (Exhibit A, pp. 339-344) dated [redacted], were presented. It was noted that Petitioner reported falling the previous night. Petitioner complained of right chest wall pain, worse with movement. A non-displaced fracture of the 11th broken rib was noted following chest radiology. Bruises to

Petitioner's chest and axilla were also noted. It was noted that Petitioner received pain medication and was discharged.

Crisis center documents (Exhibit 1, pp. 70-73, 77-80; A pp. 107-109, 116-117) dated [redacted], were presented. It was noted Petitioner was a "walk-in" and reported complaints of depression. Reported symptoms included irritability and anger. A depressed affect was noted. Limited insight and judgment were noted. An Axis I diagnosis of depression (major and recurrent) and psychosis were noted. A GAF of 50 was noted. It was noted Petitioner needed outpatient and medication management. Celexa and Seroquel were prescribed.

Hospital psychiatric documents (Exhibit 1, pp. 66-69; A pp. 110-113) dated [redacted] 2014, were presented. It was noted Petitioner presented with complaints of continued anxiety, unstable affect, and irritability despite prescribed medications. A history of suicide attempts (none within the past 25 years) was noted. Mental status examination assessments included hyperverbal, fair hygiene, cooperative, labile affect limited insight, and poor judgment. Axis I diagnoses of mood disorder, anxiety disorder, and psychotic disorder, were noted. A GAF of 50-55 was noted. A plan of continued outpatient therapy was noted.

Hospital documents (Exhibit A, pp. 19-21, 210-295) from an admission dated [redacted] were presented. It was noted that Petitioner presented with complaints of increased anxiety and a pounding heart. It was noted that an EKG and stress testing were negative for ischemia. Stress test results noted Petitioner had average functional capacity. Petitioner was prescribed various medications. A discharge date was not apparent, though [redacted] was the final date that notes were entered.

Various mental health treatment documents (Exhibit A, pp. 26-35) dated [redacted], were presented. Plans of psychotherapy and medication were noted.

Sports medicine physician office visit notes (Exhibit A, pp. 54-56, 90-92) dated [redacted] were presented. Petitioner reported a slip and fall from [redacted]. It was noted Petitioner reported he fell on his outstretched right arm which has since caused shoulder pain. Pain with range of motion was noted. It was noted x-rays showed degenerative joint changes. A diagnosis of acromioclavicular joint osteoarthritis, bicep tendinitis, and rotator cuff tendinopathy were noted. A plan for an MRI was noted.

Sports medicine physician office visit notes (Exhibit A, pp. 57-59) dated [redacted], were presented. It was noted Petitioner reported 4/10 ongoing right shoulder pain. It was noted an MRI indicated a tendon tear, atrophy, and degenerative fraying. The tear was described as "dramatic." A plan of orthopedic surgery was noted.

Sports medicine physician office visit notes (Exhibit A, pp. 93-95) dated [redacted], were presented. Ongoing complaints of right arm pain were noted. A plan for surgical evaluation was noted.

Sports medicine physician office visit notes (Exhibit A, pp. 60-62, 96-99) dated [redacted], were presented. It was noted Petitioner reported being unable to lift 5 pounds overhead with his right arm. Muscle strength of 4+/5 was noted. A plan of rotator cuff repair surgery was noted. A plan of rotator cuff surgical repair was planned. An expectation of “doing well” after surgery was indicated.

Sports medicine physician office visit notes (Exhibit A, pp. 64-66, 100-102) dated [redacted], were presented. Petitioner reported ongoing pain and weakness with his right shoulder. It was noted Petitioner canceled scheduled surgery due to other medical problems. Right shoulder muscle strength of 4/5 was noted. Surgery, following medical clearance, was noted as planned.

Hospital emergency room documents (Exhibit A, pp. 151-154, 339-344) dated [redacted] were presented. It was noted that Petitioner complained of chest pain, ongoing for several hours. The chest pain was undiagnosed though pain medication was given for shoulder pain. Chest radiology was negative for an acute cardiopulmonary process.

Treating psychiatry office visit notes (Exhibit A, pp. 103-106) dated [redacted], were presented. An Axis I diagnosis of bipolar disorder II was noted. Petitioner’s GAF was 50. A plan of increasing Seroquel and continuing psychotherapy was noted.

Hospital emergency room documents (Exhibit A, pp. 147-150, 351-355, Exhibit B, pp. 5-8) dated [redacted], were presented. It was noted that Petitioner complained of an allergic reaction to marijuana. Petitioner reported symptoms of tingly lips, neck swelling, and body swelling. It was noted Petitioner took a Benadryl and felt better. Generic discharge instructions for allergic reactions and GERD were provided.

Vascular physician documents (Exhibit 1, pp. 20-23) dated [redacted], were presented. It was noted Petitioner complained of dyspnea, chest pain, dizziness, bilateral hand and foot numbness, and constant dizziness. Petitioner reported the problems were ongoing for approximately 1 ½ years. A stress test was recommended. A NYHA functional classification of II-III was noted. A 2d echo was also recommended.

Psychiatrist progress notes (Exhibit A, p. 181) dated [redacted], were presented. Family deaths were noted to be stressors. An increase in Seroquel was noted.

Cardiac testing documents (Exhibit 1, pp. 29-56; A p. 118-123) dated [redacted], were presented. Tests included an echocardiogram, carotid duplex, and stress testing. It was noted Petitioner achieved a maximum of 8.9 METs (noted to be functional class I). It was noted Petitioner achieved 85% of age performance. Chest pain did not occur. Petitioner’s EF was noted to be 55%. Stress testing at rest was indicative of a previous infarction. It was noted EKG testing did not indicate ischemia. Global stress LV function was noted to be normal. LV myocardial perfusion and stress LV volume were noted to be normal. Testing was noted to be consistent with vessel disease. An echocardiogram report (Exhibit 1, p. 52) was noted to show grade I diastolic dysfunction.

Hospital documents (Exhibit A, pp. 73-75, 356-373, Exhibit B, pp. 13-16) from an admission dated [redacted] were presented. It was noted that Petitioner presented with complaints of racing heart, dizziness, chest pressure, dyspnea, and left arm numbness. It was noted that Petitioner received aspirin and heparin. Diagnoses included unstable angina, HTN, DM, anxiety, hyponatremia, and hypomagnesimia. A discharge date of August 17, 2015 was noted.

Therapist progress notes (Exhibit A, p. 180) dated [redacted], were presented. It was noted Petitioner spent the majority of the session "venting" about treatment during a recent hospital admission.

Therapist progress notes (Exhibit A, p. 179) dated [redacted], were presented. A depressed mood was noted. It was noted Petitioner reported fewer physical symptoms.

Vascular physician documents (Exhibit 1, pp. 24-51; A 124-125) dated [redacted] were presented. It was noted Petitioner reported chest heaviness and dyspnea with exertion. It was noted Petitioner reported a recent ER visit where he reported significant chest pain. Based on previous testing, Petitioner's dyspnea was noted to be Class II NYHA.

Lower Extremity Arterial Testing documents (Exhibit 1, pp. 57-58) dated [redacted] were presented. Normal ABIs were noted.

A psychiatric evaluation (Exhibit 1, pp. 64-65, A, pp. 81-82) dated [redacted], was presented. Petitioner presented for follow-up. Petitioner reported increasing anger and irritability. Office visit notes (Exhibit A, pp. 177-178) indicated a diagnosis of mood disorder.

Outpatient mental health treatment hospital notes (Exhibit A, p. 84) dated [redacted], were presented. Reported chest pain was noted to be consistent with anxiety. It was noted Petitioner displayed a twitch which increased at stressful times.

Cardiovascular documents (Exhibit A, pp. 16-18) dated [redacted], were presented. It was noted Petitioner underwent a ventriculography and angiographies; impressions of normal coronaries and normal ejection fraction were noted. Various medications were prescribed. A history of unstable angina and possible ischemia were noted.

Cardiologist office visit notes (Exhibit A, pp. 128-13) dated [redacted], were presented. Complaints of chest pain, dyspnea, dizziness, and arm numbness were reported. A NYHA FC of II was noted. Ranexa was prescribed for chest pain. Four days of cardiac monitoring was recommended for possible arrhythmia.

Therapist progress notes (Exhibit A, p. 176) dated [redacted], were presented. It was noted Petitioner reported frustration with his mental attitude affecting his physical problems. A depressed, irritable, and anxious mood was noted.

Therapist progress notes (Exhibit A, p. 175) dated [redacted], were presented. It was noted Petitioner reported feeling better. A depressed mood was noted.

Therapist progress notes (Exhibit A, p. 174) dated [redacted], were presented. It was noted Petitioner reported financial stressors. A depressed mood were noted.

A sudoscan report (Exhibit A, pp. 126-127) dated [redacted] (presumably intended to be [redacted]) was presented. A conclusion of normal levels of skin conductance was noted.

Therapist progress notes (Exhibit A, p. 173) dated [redacted], were presented. It was noted Petitioner reported financial stressors. An irritable mood were noted.

Psychiatrist progress notes (Exhibit A, pp. 171-172) dated [redacted], were presented. It was noted medication helped in keeping Petitioner calm.

Mental health physician office visit notes (Exhibit A, pp. 85-86) dated [redacted] 2016, were presented. Ongoing complaints of irritability and anger were noted.

Therapist progress notes (Exhibit A, p. 170) dated [redacted] were presented. It was noted Petitioner reported financial stressors. A depressed and irritable mood were noted.

Psychiatrist progress notes (Exhibit A, p. 169) dated [redacted], were presented. A constricted affect and dysphoric mood were noted. It was noted Petitioner complained of financial stressors.

Hospital emergency room documents (Exhibit A, pp. 67-69, 132-134) dated [redacted] 2016, were presented. It was noted that Petitioner presented with complaints of right shoulder pain. It was noted Petitioner postponed previously scheduled surgery because of HTN and diabetes complications; Petitioner reported to his orthopedist that his sugars were in the 400s (see Exhibit A, p. 70). Petitioner testified he adjusted his diet so that his sugar level is lower. Final diagnoses included medical noncompliance (presumably due to not getting surgery). Petitioner was discharged with a plan to see an orthopedist.

Therapist progress notes (Exhibit A, p. 168) dated [redacted], were presented. It was noted Petitioner reported he was told stress was causing his chest pain.

Therapist progress notes (Exhibit A, p. 167) dated [redacted], were presented. It was noted Petitioner was crying and reported a recent nervous breakdown.

Sports medicine physician office visit notes (Exhibit A, pp. 70-72, 87-89) dated [redacted], were presented. Ongoing right shoulder pain (7/10) was reported. Two previous rotator cuff repair surgeries were noted as scheduled. Petitioner reported a

desire to try PT. Pain and weakness were noted as physical examination findings. PT and a subacromial injection were planned.

Hospital mental health treatment notes (Exhibit A, p. 12, 50, 166) dated [redacted], were presented. It was noted Petitioner underwent Montreal Cognitive Assessment testing. Mild cognitive impairment was noted. It was noted Petitioner's "main" impairment was abstraction and memory. It was noted mood symptoms improved. An Axis I diagnosis of bipolar II disorder was noted. A GAF of 50-55 was noted.

A prescription (Exhibit A, p. 15) dated [redacted], was presented. A referral for 12 PT appointments for Petitioner's right shoulder was noted.

Sports medicine documents (Exhibit B, pp. 2-4) were presented. A diagnosis of a right rotator cuff tear was noted. A physician assistant described the tear as "massive" (see Exhibit B, p. 4). An appointment for an unspecified injection was scheduled for [redacted]

Undated surgical clearance sports medicine documents (Exhibit B, pp. 18-19) were presented. A right shoulder arthroscopy was planned.

Petitioner alleged disability, in part, due to cardiac problems. Significant cardiac testing was verified. Very few cardiac problems were verified.

Petitioner's physician described Petitioner as having Class II cardiac disease have a condition resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain. The classification is consistent with other testing which found no ischemia, a reasonable high ejection fraction, and few abnormalities.

Petitioner alleged restrictions, in part, due to arm dysfunction. Presented evidence verified extensive treatment, and also cancellations of surgeries which might have improved Petitioner's arm function.

Petitioner testified he had a nervous breakdown about 30 years ago. Petitioner testified he had another nervous breakdown 3-4 years later. Petitioner testified he was diagnosed with post-traumatic stress disorder; Petitioner testified it is related to the murder of his brother. Petitioner testified he has ongoing difficulties with stress and anxiety. Petitioner testified he struggles with violence and nervousness. Petitioner testified he has recurring crying spells. Petitioner testified he will twitch when anxious. Petitioner testified being around others makes him anxious.

Petitioner testified he sees a therapist weekly and a psychiatrist monthly. Petitioner testified he has attended mental health treatment appointments for the past 3 ½ years.

Petitioner alleged cardiac and right arm dysfunction causing restrictions to lifting/carrying, right arm repetitive activities, and ambulation. Petitioner also alleged he

has mental health problems causing non-exertional impairments to concentration, persistence, and social function. Petitioner's allegations were consistent with presented records which verified extensive treatment histories for each medical problem.

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 also alleged restrictions based on depression. Depression is an affective disorder covered by Listing 12.04 which reads as follows:

> **12.04** ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
> 1. Depressive syndrome characterized by at least four of the following:
> a. Anhedonia or pervasive loss of interest in almost all activities; or
> b. Appetite disturbance with change in weight; or
> c. Sleep disturbance; or
> d. Psychomotor agitation or retardation; or
> e. Decreased energy; or
> f. Feelings of guilt or worthlessness; or
> g. Difficulty concentrating or thinking; or
> h. Thoughts of suicide; or
> I. Hallucinations, delusions, or paranoid thinking
> OR
> 2. Manic syndrome characterized by at least three of the following:
> a. Hyperactivity; or
> b. Pressure of speech; or
> c. Flight of ideas; or
> d. Inflated self-esteem; or
> e. Decreased need for sleep; or
> f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking

OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Psychological treatment documents sufficiently verified symptoms of insomnia, concentration difficulty, and loss of energy. Most notably, regular psychomotor abnormalities were documented. It is found Petitioner meets Part A of the affective disorder listing.

Petitioner alleged he has marked social and persistence/concentration difficulties. Petitioner's allegation was consistent with statements from his psychiatrist.

A Mental Residual Functional Capacity Questionnaire (Exhibit A, pp. 7-11) dated [redacted], was presented. The form was completed by a psychiatrist with an approximate 9-month history of treating Petitioner. An Axis I diagnosis of bipolar disorder was noted. It was noted prescribed medication (Seroquel, Depakote, and Klonopin) was needed to address Petitioner's paranoia and violence; ongoing struggles with concentration and irritability were noted to be ongoing obstacles. Mild impairment to executive functioning and executing commands was noted. It was noted Petitioner was unable to meet competitive standards in the following work abilities: maintaining

attention for 2 hours, maintaining attendance and punctuality, working in coordination with others, completing a workday without psychological interruption, performing at a consistent pace without a reasonable number/length of rest periods, getting along with coworkers without distraction or behavioral extremes, responding appropriately to work setting changes, being aware of normal hazards, understanding detailed instructions, carrying out detailed instructions, or dealing with stress of semi-skilled or skilled work. Petitioner was determined to have no useful ability to accept instructions while responding appropriately to supervisors, dealing with work stress, or setting realistic goals or plans independently of others. The psychiatrist noted the restrictions were supported by Petitioner's difficulties with impulse control, regulating emotions, poor concentration, and being unable to accept criticism. The psychiatrist opined Petitioner would have to miss more than 4 days per month due to impairments. The restrictions stated by Petitioner's psychiatrist were consistent with Petitioner's psychiatric history (also see Exhibit a, pp. 182-197).

Petitioner's GAF was noted to be 45. A GAF of 50 was noted to be Petitioner's highest from the last 12 months. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF within the range of 41-50 is representative of a person with "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job)." Petitioner's GAF is consistent with marked restrictions to concentration and social interaction.

It is found Petitioner established marked restrictions to concentration and social function. Accordingly, Petitioner meets the listing for affective disorders and is a disabled individual. Accordingly, it is found MDHHS improperly denied Petitioner's SDA application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law finds that MDHHS improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];
(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/hw

Christian Gardocki
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]

Authorized Hearing Rep. [redacted]

Petitioner [redacted]