STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 21, 2016
MAHS Docket No.: 16-011781
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 September 22, 2016, from Warren, Michigan. Petitioner appeared and was unrepresented. [redacted], Petitioner's partner, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

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. 486-492).

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. 2).

6. As of the date of the administrative hearing, Petitioner was a 32-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 an associate degree (in applied science).

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

10. Petitioner alleged disability based on restrictions related to various psychological 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).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), 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 (January 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.

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. It was not disputed MDHHS denied Petitioner's application following a determination that Petitioner was not disabled.

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 [90 days for SDA eligibility]. 20 CFR 416.905.

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.

An Initial Evaluation with a mental health treatment agency (Exhibit 1, pp. 168-178, 263-273) was presented. The evaluation was completed on [redacted], and cosigned by a psychiatrist and a social worker. Petitioner reported difficulty with focus, poor impulse control, distractibility, hoarding, racing thoughts, anxiety, insomnia, panic attacks, and irritability. It was noted Petitioner left a previous mental health agency after being dissatisfied with services. Mental health examination assessments included normal behavior, anxious mood, normal affect, normal thought content, normal psychomotor activity, verbose speech, and orientation x3. A primary Axis I diagnosis of generalized anxiety disorder was noted. Secondary diagnoses included bipolar disorder and ADHD (inattentive type). A GAF of 46 was noted. Recommendations included individual therapy, medication management, and a psychiatric evaluation.

Treatment plan notes (Exhibit 1, pp. 165-167, 260-262) dated [redacted], were presented. Petitioner's goals included not feeling defeated, more positive thinking, decreased irritability, setting reasonable limitations, and fewer destructive thought patters.

Medication review notes (Exhibit 1, pp. 159-164, 254-259) dated [redacted], were presented. Petitioner reported slight improvements in distractibility and concentration. Active medications included Klonopin, Vyvanse, and Trazodone.

Medication review notes (Exhibit 1, pp. 153-158, 248-253) dated [redacted], were presented. Petitioner reported nighttime irritability and agitation. Active medications included Adderall, Clonazepam, and Trazodone. Petitioner reported increased weight. A mildly distractible mood was noted. A GAF of 62 was noted.

Medication review notes (Exhibit 1, pp. 147-152, 242-247) dated [redacted], were presented. Petitioner reported nighttime irritability and agitation. Active medications included Adderall, Clonazepam, and Trazodone. Petitioner reported increased anxiety and a desire for more therapy. Mental health examination assessments were unremarkable.

Medication review notes (Exhibit 1, pp. 141-146, 236-241) dated [redacted], were presented. Petitioner reported nighttime irritability and agitation. Active medications included Adderall, Ativan, and Trazodone. Mental health examination assessments were unremarkable other than an irritable affect. A GAF of 35 was noted in post-dated documents (see Exhibit 1, p. 190, 475) .

Progress notes (Exhibit 1, pp. 138-140, 233-235) dated [redacted], were presented. The notes were signed by a counselor. It was noted Petitioner reported feeling defeated in unspecified areas of life. It was noted Petitioner struggled with seeing the daily life effects of his actions. Mental health examination assessments were unremarkable. Petitioner expressed interest in learning coping skills.

Progress notes (Exhibit 1, pp. 135-137, 230-232) dated [redacted], were presented. The notes were signed by a counselor. It was noted Petitioner reported feeling irritable when around distressing people. A low internal locus of control over everyday actions was noted. Mental health examination assessments were unremarkable, other than Petitioner appearing restless and ruminative in thought. Cognitive behavioral therapy (CBT) exercises were performed.

Progress notes (Exhibit 1, pp. 132-134, 227-229) dated [redacted], were presented. The notes were signed by a counselor. It was noted Petitioner reported "consistent worries" in life. A low internal locus of control was noted.

Medication review notes (Exhibit 1, pp. 124-129, 219-224) dated [redacted], were presented. Petitioner reported minor depression and feeling less irritable. Active medications included Adderall, Ativan, and Trazodone.

Progress notes (Exhibit 1, pp. 118-120, 213-215) dated [redacted], were presented. The notes were signed by a counselor and psychiatrist. Mental health examination assessments indicated no abnormal or remarkable behavior. Petitioner reported racing thoughts and mood swings. It was noted Petitioner has "extensive difficulty" with internal locus of control. Various goals for Petitioner (see Exhibit 1, pp. 121-123, 216-218) were discussed.

Medication review notes (Exhibit 1, pp. 31, 112-117, 207-212) dated [redacted], were presented. Petitioner's mood was noted to be anxious and dysphoric. Active medications included Ativan, Lamictal, and Trazodone.

Counselor notes (Exhibit 1, pp. 28-30, 109-111, 204-206) dated [redacted], were presented. Petitioner reported complaints of mood swings, sadness, lack of self-control, and feeling different. It was noted Petitioner reported he was unable to work. It was noted Petitioner appeared anxious and depressed. It was noted Petitioner displayed good insight into his problems.

Medication review notes (Exhibit 1, pp. 22-27, 103-108. 198-203) dated [redacted] were presented. Petitioner reported complaints of irritability, instability, insomnia, and anger. Mental health assessments included irritable mood. Active medications included Ativan, Lamictal, and Trazodone.

Various therapy discharge documents (Exhibit 1, pp. 7-16, 89-97, 184-192) dated [redacted], were presented. It was noted Petitioner refused to attend intake and said that his doctor and all persons at the agency were idiots. Petitioner demanded a different physician and therapist. When told he would not receive one, Petitioner stated he was leaving the agency. Active medications included Ativan, Lamictal, and Trazodone.

Psychiatric office visit notes (Exhibit 1, pp. 477-483) dated [redacted], were presented. It was noted Petitioner reported ongoing mood swings, agitation, and low self-esteem. Petitioner reported a history of difficulty holding employment. Fair insight and fair judgment were noted in a mental health examination. Prozac and dextroamphetamine were prescribed.

A Psychiatric Evaluation (Exhibit 1, pp. 469-476) dated [redacted], was presented. Petitioner reported a desire for therapy to speak about a bad job experience, coping skills, and alternative therapies. Petitioner reported he was a hoarder and had low motivation. Petitioner reported feeling anxious when looking for employment. Other reported symptoms included mood swings, racing thoughts, financial worries, crying spells, poor sleep. Petitioner reported he skips showers and has not left his home for a

week. A history of insomnia and decreased appetite was noted, though it was also noted Petitioner now sleeps 10-12 hours/day and that he gained 17 pounds in the past month. Washing hands for 20-30 times (it was not stated how often) was noted. A history of being in therapy 7-8 times was reported; Petitioner denied psychiatric hospitalizations. Petitioner reported he stopped attendance at his last agency because he did not see a therapist enough. It was noted Petitioner recently left employment after his supervisor laughed after a customer reportedly threatened to hit Petitioner. Petitioner had been at the job for over a year. Active medications included Ativan, Gabapentin, Lamictal, and Trazodone. Mental health assessments were unremarkable, other than racing thoughts.

Hospital documents (Exhibit 1, pp. 35-83) from an admission dated [redacted], were presented. It was noted that Petitioner complained of skin rash and chest pain. It was noted Petitioner was admitted due to the severity of the rash and Petitioner's history of hypertension. It was noted chest radiology was negative. An EKG was noted to show no ischemic changes. Chest pain was suspected to be musculoskeletal. It was noted that Petitioner received medication and his rash improved. Discharge diagnoses of maculopapular rash and atypical chest pain were noted. A discharge date of [redacted] was noted.

Psychiatric office visit notes (Exhibit 1, pp. 484-485) dated [redacted], were presented. It was noted Petitioner reported ongoing anxiety.

Petitioner testimony did not allege any severe exertional restrictions related to employment. A single hospital treatment for a skin rash and chest pain were verified. The accompanying treatment and diagnoses were indicative of a temporary condition. It is found Petitioner has no exertional and/or physical severe impairments.

Petitioner testified he is currently incapable of employment due to his psyche. Petitioner testified he is simply not motivated, his medications make him irritable and tired, and mood swings and OCD further complicate matters. Petitioner thinks Geodon (a mood stabilizer) is the medication which makes him tired. Petitioner also testified he takes Trazodone and Ativan (both anti-anxiety medications).

As an example, Petitioner testified he had 3 breakdowns in the last week where he cried for over an hour and could not leave his home. Petitioner testified another illustration of his symptoms was when he had recent difficulty trying to hang a mirror which resulted in Petitioner kicking and yelling. Petitioner speculated he might "have a freak-out" if he was told what to do by a supervisor.

Petitioner testified he prefers, when feeling depressed, to be isolated from others. Petitioner testified depression also causes him to slack on hygiene (e.g. not showering for days). Petitioner testified he saves mail for several months, but he cannot explain why.

Presented documentation referenced a history of psychiatric treatment for Petitioner since the third grade. Petitioner believes his mental health contributed to him having so many jobs; he testified he's had 30-40 different jobs in his life.

Petitioner testified he has pursued psychiatric treatment consistently over the last 2 years in an attempt to overcome his symptoms. Petitioner testified he has been with the same psychiatrist for the past 9 months. Petitioner testified he sees a therapist weekly. Petitioner testified his therapist recommends grounding exercises which help with breathing and judgment. Petitioner testified he tries to attend yoga. Despite treatment, Petitioner testified he does not feel like he is improving.

Presented documentation sufficiently verified a treatment history for unstable moods, anhedonia, sleep difficulties, anger outbursts, and anxiety. The treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. 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.

A primary diagnoses of generalized anxiety disorder was verified. Anxiety disorders are covered by Listing 12.06, which reads as follows:

> **12.06** ***Anxiety-related disorders***: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.
>
> 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 both A and C are satisfied.
>
> A. Medically documented findings of at least one of the following:
> 1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
> a. Motor tension; or
> b. Autonomic hyperactivity; or
> c. Apprehensive expectation; or
> d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

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. Resulting in complete inability to function independently outside the area of one's home.

Presented evidence sufficiently verified a history of weekly anxiety attacks (at minimum). It is found Petitioner meets Part A of the above listing. The analysis will proceed to determine if Petitioner meets Parts B or C.

The most recent verified GAF was 35. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM IV) states that a GAF level of 31-40 is described as “some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.”

It is questionable whether a “major impairment” in “several areas” was established. There was no evidence of reality impairment (e.g. hallucinations). There was evidence of impairment in other areas.

Petitioner alleged his psychological symptoms adversely affect the relationship with his partner, his thinking, his mood, and ability to work.

Petitioner and his partner testified to difficulties within their relationship. Petitioner’s partner testified Petitioner is upset on a daily basis. For example, Petitioner will yell about chores not being done. Petitioner’s partner testified Petitioner is difficult to calm, and he seems to be getting worse. Petitioner’s partner testified he gets anxious from Petitioner’s outbursts. The testimony was unquestionably indicative of restrictions, but not necessarily “major” restrictions.

There was no apparent history of suicidal ideation. There was no history of physical violence. There was no history of threatened violence. There was no history of

psychiatric hospitalizations. These considerations are indicative of non-major restrictions.

"Major" and/or "marked" impairments can be demonstrated by assessments from mental health examinations. Petitioner's examinations typically consistently noted very few remarkable or alarming indicators. There was no indication of psychomotor dysfunction, non-orientation, irrational or illogical thought process.

A limited insight and/or judgment might be indicative of low function, however, Petitioner's insight and judgment were noted to be fair-to-good. Petitioner's most recent evaluation noted Petitioner displayed "generally good judgment" and "recognizes own strengths and weakness." The assessments are neither indicative of major dysfunction and/nor marked restrictions.

A GAF of 35 might have been more compelling had it been validated closer to Petitioner's hearing date. Evidence of Petitioner's GAF in the 11 months before hearing was not apparent. It had been over 6 month between Petitioner's GAF assessment and date of SDA application.

A listing for affective disorder (Listing 12.04) was considered based on diagnoses of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation, or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

It is found that Petitioner failed to establish meeting (or equaling) a SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified he has a history of dozens of jobs, the majority of which were part-time. Petitioner testified he worked full-time as an account manager and film editor.

Petitioner testified he is not capable of performing any of his past jobs due to psychological problems. For purposes of this decision, Petitioner's testimony will be accepted. It is found Petitioner cannot perform past, relevant employment amounting to SGA from the past 15 years. Accordingly, the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Petitioner failed to establish any exertional restrictions. The analysis will determine if and how Petitioner's non-exertional restrictions restrict potential employment.

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

Petitioner's treatment history was most indicative of social and/or concentration impairments. It is appreciated that Petitioner would have difficulty performing employment reliant on social interactions due to his recurring irritability, mood swings, and inclination for social isolation. It is also appreciated that Petitioner's distractibility would preclude Petitioner's performance of relatively complex employment. Presented evidence was not sufficiently persuasive to justify rejecting Petitioner's performance of simple and repetitive employment not heavily reliant on social interactions.

MDHHS did not present vocational information of employment which Petitioner could perform. Despite the absence of presented evidence, job titles from the Dictionary of Occupational Titles within Petitioner's capabilities include: custodian, data entry, stockperson, and machine operator. MDHHS did not present evidence of the availability of jobs which Petitioner could perform, however, the jobs are common enough that it is probable that ample employment opportunity exists for Petitioner.

It is found Petitioner is capable of performing other employment. Accordingly, Petitioner is not a disabled individual and it is found that MDHHS properly 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 properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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]

Petitioner

[redacted]