RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed: June 10, 2016
MAHS Docket No.: 16-003493
Agency No.:
Petitioner:

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 April 27, 2016, from Detroit, Michigan. Petitioner appeared and represented herself. Her daughter, , appeared and testified on her behalf The Department of Health and Human Services (Department) was represented by , PATH Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The medical packet reviewed by the Disability Determination Services (DSS)/Medical Review Team (MRT), including records referenced in the DDS/MRT disability determination explanation admitted as Exhibit B, were received and admitted into evidence as Exhibit C; the DHS-49 F was received and admitted into evidence as Exhibit D; Petitioner's hospital records from from March 2016 were received and admitted into evidence as Exhibit G; and medical documents submitted by Petitioner at the time of application were received and admitted into evidence as Exhibit 1. The record closed on May 27, 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 January 11, 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability (Exhibit A).

2. On March 7, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit B).

3. On March 8, 2016, the Department sent Petitioner a Notice of Case Action denying the application based on MRT's finding of no disability (Exhibit E).

4. On March 14, 2016, the Department received Petitioner's timely written request for hearing concerning the denial of her SDA application and the amount of her State Emergency Relief (SER) grant.

5. Petitioner alleged disabling impairment due to right wrist injury, headaches and dizziness, left arm numbness, right leg issues causing balance problems, and severe depression.

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

7. Petitioner completed the [redacted] grade.

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

9. Petitioner has an employment history of work as a photo technician and assembly line worker.

10. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

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

Petitioner requested a hearing disputing the Department's denial of her SDA application and the amount of her SER grant. At the hearing, she testified that the SER issue had been resolved and she no longer wished to pursue a hearing on that matter. Therefore

Petitioner's March 14, 2016 hearing request concerning her SER issue is dismissed. The hearing proceeded to address the denial of Petitioner's SDA application.

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.

The evidence at the hearing established that Petitioner had been receiving cash assistance under the Family Independence Program (FIP) but her case was closed because she exceeded the time limit for receipt of FIP benefits. In her January 11, 2016 application, Petitioner sought cash assistance alleging a disability. A disabled person is eligible for cash assistance under the SDA program. 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 was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, she 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 right wrist injury, headaches and dizziness, left arm numbness, right leg issues causing balance problems, and severe depression. The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

Petitioner was diagnosed with right wrist sprain on October 9, 2014 (Exhibit C, p.114). She was examined on October 30, 2014 alleging that her wrist still hurt but felt better and she had problems with gripping movements. She denied any numbness or tingling in her arms. The doctor noted full range of motion with flexion and extension and good

grip strength. He diagnosed her with right wrist sprain and indicated she could return to work with restricted use of the right hand. (Exhibit C, p.101.)

Petitioner was assessed for physical therapy on November 21, 2014 which found deficits in right wrist range of motion as follows: extension was at 37°, flexion was at 44°, radial deviation was a 15°, and ulnar deviation was at 19°. There was also gross muscle strength of 3/5 at the right radiocarpal joint. Petitioner participated in physical therapy for 8 weeks beginning November 21, 2014 (Exhibit C, pp. 103-113, 115-121, 123-130.) At a doctor visit on February 25, 2015, she continued to complain of pain in the right wrist and intermittent tingling and numbness that occasionally interfered with her sleep. Her wrist range of motion was from 60° of flexion to 60° of extension. The doctor observed that Petitioner was unable to make a fist and had a positive Tinel's of the right carpal tunnel. Petitioner was referred for on EMG nerve conduction to evaluate for potential carpal tunnel syndrome and MRI of the right wrist to evaluate for possible structural injuries. (Exhibit C, pp. 129-130.) The EMG came back negative, and the MRI came back is consistent with a sprain. (Exhibit C, p.132.)

On February 25, 2015 Petitioner was examined after a February 18, 2015 accident when a cart fell on her head. She subsequently complained of dizziness with a headache and was referred by her employer to ██████ ██████ emergency department. A CT scan of the skull was negative. Because an x-ray of the cervical spine showed a deformity involving the posterior margin of C1, her doctor recommended a CT scan of the cervical spine (Exhibit C, pp. 142-143, 190-206.)

On March 9, 2015, Petitioner reported that she was injured on the job on March 3, 2015, and after she developed increased pain in her neck radiating down into her left arm with tingling, she went to ████████████████ where she was informed she had a neck injury. Hospital tests revealed a negative head CT, unremarkable C-spine CT, and a history for hypertension and HIV with her most recent CD4 count of 836 in August 2014. In reviewing the CT scan of March 3, 2015, the doctor noted mild diffuse disc bulge at the C4/C-5 level as well as spurring and arthritis present at the neck; no fractures were seen. The doctor concluded that Petitioner suffered a skull contusion with neck strain. (Exhibit C, pp.145; 226-242.) On May 11, 2015, Petitioner reported dizziness, arm and hand pain, and headaches from the March 3, 2015 injury. (Exhibit C, pp. 80-81.)

On August 22, 2015, Petitioner went to her doctor complaining of right wrist injury the prior day while at work. She complained of pain and decreased range of motion and swelling. X-ray results were negative. She was diagnosed with a forearm contusion. (Exhibit C, pp. 156-159, 172.) At an August 28, 2015, visit the doctor noted that the right forearm appeared normal, with no deformity or tenderness, and with functional range of motion and normal strength (Exhibit C, PP 160-162.)

On August 30, 2015 Petitioner went to a pain clinic and described work injuries that resulted in constant right wrist pain that started October 9, 2014, neck pain with radiation to the left arm upper extremity that started on February 18, 2015, and low back

pain with radiation to the right lower extremity that started on August 21, 2015. An August 24, 2015 MRI of the cervical spine was unremarkable. A March 26, 2015 MRI of the right wrist showed no definite acute osseous abnormality and mild increase in signal involving the triangular fibrocartilage which could represent a degree of sprain. (Exhibit C, pp. 216-220, 258-259.)

On November 16, 2015, Petitioner went to the emergency department complaining of right wrist pain and intermittent episodes of dizziness, reporting that two days prior she had an episode of dizziness, fell, and caught herself with her outstretched right hand, and since then had soreness at her hand. She denied any numbness or tingling or weakness in the hand or forearm. X-rays of her right hand and wrist showed no acute fracture, dislocation, or subluxation but there were findings suggestive of bony injury. She was referred to as a sports medicine clinic. A brain MRI was unremarkable other than changes likely related to Petitioner's HIV status and anemia. (Exhibit C, pp. 260-266)

On January 30, 2016, Petitioner underwent a psychiatric evaluation by a psychiatrist at the Department's request. Petitioner reported suffering a concussion at work and taking time off work because of severe headaches, dizziness and depression, but when she returned a few months later, she continued to suffer from dizziness that caused her to fall a few times. She also suffered from memory problems. Petitioner reported no history of significant depression or psychiatric problem in the past but had recently scheduled an appointment at [redacted] for treatment of her depression and poor attention span. She denied taking any psychotropic medication, being admitted to a psychiatric hospital, or having past suicide attempts. The doctor observed that Petitioner was in contact with reality and not responding to internal stimuli. She had average self-esteem; normal psychomotor activity; fair motivation; good insight into her illness; slow thought process; and goal-directed speech. She denied auditory or visual hallucinations or paranoid delusions or suicidal or homicidal ideations. Her mood was depressed and tearful. Her affect was labile and appropriate. She was oriented to time, person, and place. She did not tend to exaggerate her symptoms. The doctor diagnosed Petitioner with adjustment disorder with depression and cognitive impairment due to general medical condition. He concluded that her global assessment of functioning (GAF) score was 46 and her prognosis was guarded. (Exhibit C, pp. 95-97.)

On February 25, 2016, Petitioner had on initial assessment with a community mental health services. She received a preliminary diagnosis of adjustment disorder with depressed mood and a secondary diagnosis of major depressive disorder, single episode, moderate. (Exhibit 1.)

On March 11, 2016, Petitioner went to the emergency department complaining of right leg pain shooting down her buttock to the back of her right leg following a fall from her car two days earlier. The doctor noted some tenderness over the medial right thigh and a little bit on the hip, full range of motion passively with only minimal pain, and a neurovascularly intact right leg. The doctor indicated that he suspected musculoskeletal

pain with low concern for fracture. Petitioner was diagnosed with sciatica secondary to post fall, treated symptomatically and discharged in stable condition. (Exhibit C.)

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 1.02 (major dysfunction of a joint), 4.04 (ischemic heart disease), 11.14 (peripheral neuropathies), 12.04 (affective disorders), and 14.08 (human immunodeficiency virus (HIV) infection), were considered. 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). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(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 her medical condition. Petitioner testified that she could walk no more than a half city block before needing to rest and stand no more than 15 minutes before her legs got week. She testified that she had no problems sitting, but her right leg hurt. She had difficulty gripping with her right hand because her arm hurt from the fingers to the elbow. She could not lift her 38 pound [redacted] and could not lift a gallon of milk with her right hand. She lived with two adult children, one who was mentally disabled adult, and her

five minor children. Her daughter helped her get in the tub and get dressed. According to Petitioner and her adult daughter, the older children did all of the household chores.

Petitioner's medical records show that Petitioner was diagnosed with right wrist sprain on October 9, 2014, participated in 8 weeks of physical therapy but continued to complain of pain in the right wrist with intermittent tingling and numbness that occasionally interfered with her sleep. Following therapy, on February 25, 2015, the doctor observed wrist range of motion from 60° of flexion to 60° of extension (normal extension is 70° and normal flexion is 75°) http://www.eatonhand.com/nor/nor002.htm. The doctor observed that Petitioner was unable to make a fist and had a positive Tinel's of the right carpal tunnel. However EMG nerve conduction studies were negative, and an MRI of the right wrist came back is consistent with a sprain. Petitioner also complained of dizziness with headaches and left arm numbness following a February 18, 2015 work accident. A CT of the head and of the C-spine were unremarkable, and the doctor concluded that Petitioner suffered from a skull contusion with neck strain. On November 16, 2015, Petitioner went to the emergency department complaining of dizziness and right wrist pain but denied any numbness or tingling or weakness in the hand or forearm. While x-rays of the right hand and wrist showed no acute fracture, dislocation, or subluxation, there were findings suggestive of bony injury and Petitioner was referred to a sports medicine clinic.

While Petitioner's medical documents support her testimony that she had some limitations due to wrist pain, headaches and dizziness, her statements concerning the intensity, persistence and limiting effects of these symptoms are not fully supported by the clinical findings in the file. 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 light work as defined by 20 CFR 416.967(b).

Petitioner also alleges of nonexertional limitations due to her mental condition and due to dizziness. She testified that she suffered from severe depression and had trouble sleeping. She had issues with her concentration and suicidal thoughts. She started attending mental health counseling in February 2016.

Petitioner's initial assessment with the community mental health services provider on February 25, 2016 showed a preliminary diagnosis of adjustment disorder with depressed mood and a secondary diagnosis of major depressive disorder, single episode, moderate. The independent medical examiner who evaluated Petitioner on January 30, 2016 also diagnosed her with adjustment disorder with depression and cognitive impairment due to general medical condition and assigned her a GAF score of 46. The independent examiner found that she had average self-esteem; normal psychomotor activity; fair innovation; good insight into her illness; slow thought process; and goal directed speech. Petitioner reported that she had never had any psychiatric hospitalization and had never taken any psychotropic medication. Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on her mental ability to perform basic work activities and is not precluded

from performing simple, one and two step unskilled work. Because Petitioner's medical record indicates problems with dizziness, her nonexertional RFC also limits her from engaging in hazardous activity.

Petitioner's RFC is considered at both Steps 4 and 5. 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 photo technician and an assembly line worker. Both jobs required that Petitioner stand all day. As a photo technician, petitioner testified that she regularly lifted up to 50 pounds and could have to lift up to 100 pounds. Based on these lifting requirements, Petitioner's job as a photo technician is properly categorized as involving heavy work. As an assembly line worker at [redacted]r, Petitioner regularly lifted 10 pounds but no more than 15 pounds. This job is properly categorized as involving light work.

Based on the RFC analysis above, Petitioner is limited to light work activities. Based on her exertional RFC, she is capable of past relevant work as an assembly line worker. Petitioner also has mild to moderate limitations in her mental capacity to perform basic work activities. Based on her nonexertional RFC, she is capable of simple, unskilled work provided that she is not engaged in hazardous activities. Her prior employment involved simple, unskilled work and was not in a hazardous setting. Therefore, Petitioner is able, based on her RFC, to engage in the past relevant work. Because Petitioner is able to perform past relevant work, she is not disabled at Step 4, and the assessment ends.

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

Based on Petitioner's testimony, her request for hearing concerning her SER application is **DISMISSED.**

The Department's SDA determination is **AFFIRMED.**

ACE/tlf

Alice C. Elkin
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