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: June 24, 2016
MAHS Docket No.: 16-005648
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 May 25, 2016. Petitioner appeared and was unrepresented. Petitioner's niece's mother, [redacted] testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted] [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. 5-9, Exhibit 2, pp. 1-5), in part, based on a Disability Determination Explanation (Exhibit 2, pp. 6-35).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action (Exhibit 1, pp. 3-4) informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits.

6. On [redacted], an administrative hearing was held.

7. During the hearing, Petitioner and MDHHS waived the right to receive a timely hearing decision.

8. During the hearing, the record was extended 30 days to allow MDHHS to submit medical records utilized in the determination denying SDA benefits; an Interim Order Extending the Record was subsequently mailed to both parties.

9. On [redacted] MDHHS submitted additional documents (Exhibit 2, pp. 1-461)

10. As of the date of the administrative hearing, Petitioner was a 54-year-old female.

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

12. Petitioner's highest education year completed was the 11th grade.

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

14. Petitioner alleged disability based on restrictions related to hip pain, back pain, recurring bronchitis, and anxiety.

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 an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 3-4) verifying Petitioner's claim of disability was denied.

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.

Hospital documents (Exhibit 2, pp. 219-222) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of chest pain, ongoing for 24 hours. EKG results were noted to be unremarkable.

Hospital documents (Exhibit 2, pp. 204-218) dated [redacted], were presented. It was noted that Petitioner presented with a complaint of abdominal pain, ongoing for 24 hours. Abdomen radiology demonstrated no obstruction. A CT of Petitioner's pelvis was noted to be a negative study, though leiomyomata (uterine fibroids) was indicated. Petitioner was admitted based on elevated lipase. Petitioner received fluids, pain medication, and bowel rest. Pain was "much better" at discharge. A discharge diagnosis of acute abdominal pain was noted. Petitioner was discharged on [redacted].

Physician office visit notes (Exhibit 2, pp. 374-378) dated [redacted], were presented. Petitioner presented for a physical. A complaint of back pain was noted. Petitioner reported she was at a friend's house last month, when a gutter fell on her head. Petitioner reported the jolt caused her to fall backwards onto concrete. Petitioner reported symptoms of headaches, left-sided neck pain, left shoulder pain, and bilateral leg pain. Norco was prescribed.

Physician office visit notes (Exhibit 2, pp. 371-373) dated [redacted], were presented. Petitioner presented for a physical. A compliant of back pain was noted. Petitioner reported Norco or Percocet relieved reported pain. Percocet was prescribed.

A lumbar x-ray report (Exhibit 2, p. 457) dated [redacted], was presented. An impression of minimal degenerative changes was noted.

Physician office visit notes (Exhibit 2, pp. 368-370) dated [redacted], were presented. Petitioner presented with complaints of left shoulder pain. Petitioner reported that taking a stronger dose of Percocet is helpful. Shoulder stiffness was noted. A referral to pain specialist was provided. A referral to a neurologist for complaints of unspecified numbness and tingling.

Physician office visit notes (Exhibit 2, pp. 365-367) dated [redacted], were presented. Petitioner presented with complaints of cough and back pain. An appointment with pain management was noted as scheduled.

Physician office visit notes (Exhibit 2, pp. 202-203, 362-364) dated [redacted], were presented. Petitioner reported heavy menstrual bleeding. A colonoscopy report was noted to demonstrate a normal colon and enlarged hemorrhoids.

Physician office visit notes (Exhibit 2, pp. 356-361) dated [redacted], were presented. It was noted Petitioner presented for blood pressure and back pain treatment. Petitioner reported concerns of recurring boils on her body. Percocet was prescribed for back pain.

A lumbar MRI report (Exhibit 2, p. 456, 459) dated [redacted], was presented. Mild diffuse posterior disc bulging was noted at L2-L5; no clear evidence of herniation was noted. Mild-to-very mild impingement of neural foramen was noted. No stenosis was indicated. An overall impression of mild degenerative changes without spondylolisthesis was noted.

Hospital emergency room documents (Exhibit 2, pp. 272-273, 347-355, 417-420) dated [redacted], were presented. It was noted that Petitioner presented for a physical. A radiology report of Petitioner's lumbar demonstrated mild degenerative changes. Hip joint radiology was noted to be unremarkable (see Exhibit 2, p. 423-425). It was noted Petitioner was referred to PT for hip and back pain. Weight loss and healthy lifestyle instructions were indicated. Blood work was noted to be normal (see Exhibit 2, p. 382).

Physician office visit notes (Exhibit 2, pp. 343-346) dated [redacted], were presented. Petitioner reported ongoing shoulder and lumbar pain. It was noted Petitioner needed to lose weight. It was noted Petitioner seemed to have severe arthritis in fingers, hands, and wrist. Back pain was noted to be likely due Petitioner's weight. Petitioner reported not wanting to see a psychiatrist. Petitioner reported wanting a job not requiring prolonged sitting, standing, or lifting/carrying. A normal right hip was noted following an x-ray (Exhibit 2, p. 414). Petitioner reported she regained health insurance and wants to continue PT and pursue pain management. Petitioner was given Biofreeze for her knee and shoulder; other medications were prescribed

Physician office visit notes (Exhibit 2, pp. 317-322, 332-334) dated [redacted], were presented. Petitioner presented with a primary complaint of muscle cramping in legs, lower abdomen, and back. Incontinence was reported as side-effect of cramping. Physical examination findings included normal musculoskeletal range of motion. It was also noted Petitioner was referred to an ENT physician for a biopsy. Diagnoses of muscle cramping, HTN, and lymphadenopathy, tobacco abuse, anxiety, and chronic pain were noted.

Physician office visit notes (Exhibit 2, pp. 47-48) dated [redacted], were presented. It was noted that Petitioner presented for ongoing treatment of a submandibular mass. It was noted Petitioner was unable to obtain an excision biopsy because of insurance restrictions.

A mental status examination report (Exhibit 2, pp. 93-96) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported feeling depressed due to various physical problems. No psychiatric treatment history was reported. Petitioner reported she watches television most of the day. Notable observations and assessments of Petitioner included logical stream of mental activity, cooperative attitude, slightly depressed mood, and unremarkable affect. A diagnosis of dysthymia related to medical problems was noted. It was stated Petitioner had no psychiatric or cognitive inability preventing employment. A guarded prognosis was noted.

Petitioner testimony implied impairments related to anxiety. A diagnosis and a script for anxiety medication (Petitioner takes Alprazolam) was verified (see Exhibit 2, p. 318). Petitioner testified she does not see a psychiatrist. Petitioner testimony indicated no psychiatric history. The only presented medical record was a consultative examination

which indicated Petitioner had no psychiatric barriers. It is found Petitioner failed to establish an impairment related to anxiety.

Petitioner testimony alleged recurring bronchitis limits her breathing. A need for respiratory medication (Albuterol) was verified (see Exhibit 2, p. 318). It was also established Petitioner was a smoker as recently as 2015. Petitioner testified she needs a breathing machine, though presented evidence failed to verify the need. Respiratory restrictions were not indicated. Abnormal chest radiology was not verified. Complaints of dyspnea were not documented. Petitioner failed to establish any restriction related to dyspnea.

Petitioner testified she worked as a nursing assistant in 2009 when she hurt her left shoulder. Petitioner testified she had surgery and returned to work, however, she experiences recurring shoulder pain. Petitioner testified she also hurt her back when trying to lift a patient. Petitioner testified she underwent PT and injections. Petitioner testified injections increased her pain.

Petitioner testified she experiences leg numbness and/or tingling. Petitioner testified she has nerve damage after she was in the head with a gutter.

Petitioner testimony alleged a degree of lifting/carrying limitations due to back pain, shoulder pain, leg weakness, and hip pain. Petitioner's testimony was consistent with presented records.

It is found Petitioner has work-related restrictions which 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 listing for spinal disorders (Listing 1.04) was considered based on Petitioner's lumbar complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

A listing for peripheral neuropathies (Listing 11.14) was factored based on a complaints of leg numbness. The listing was rejected due to a failure to establish significant and persistent disorganization of motor function in two extremities.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treating physician's diagnosis of an anxiety disorder. 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 had a complete inability to function outside of the home.

It is found that Petitioner failed to establish meeting 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 she last worked in 2012 as a nursing assistant. Petitioner testified her duties included showering, dressing, and transferring patients. Petitioner testified she could not perform the lifting/carrying required of her former employment.

Petitioner testified she also worked as machinist and shipper/handler for a factory. Petitioner testified she had to move a lot of auto parts. Petitioner testimony estimated the job required bending 50-100 times per hour which she can no longer perform. Petitioner also testified she stood her entire shift.

Petitioner's testimony that she is unable to perform past employment was credible and consistent with presented records. It is found Petitioner cannot perform past and relevant employment form 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.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though 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. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

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). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

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). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id*.

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).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform light employment. Social Security Rule 83-10 states that the full range of light work requires standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday.

Petitioner testified she rarely leaves her home due to ambulation difficulties. Petitioner testified she can only walk ½ block before her back and hips hurt. Petitioner testified she is restricted to 20-30 minutes of standing due to back and hip pain. Petitioner testified she can sit for a 1 hour maximum period; Petitioner was unsure how much rest she'd need to return to sitting. Petitioner's witness testified Petitioner takes 30 minutes to go down 14 steps. Petitioner testified she can lift a gallon of milk, but was unsure if she could lift/carry a higher amount of weight. Petitioner testified she does not use a cane.

Petitioner testified she has no problems showering, but she has difficulty getting up from a bath. Petitioner testified she has difficulty braiding her hair because of left shoulder raising restrictions. Petitioner testified she is unable to perform vacuuming or sweeping due to back pain. Petitioner testified she can sometimes shop by herself. Petitioner testified she stopped driving because of difficulty turning a steering wheel.

Petitioner's testimony was indicative of an inability to perform light employment. Petitioner's testimony was not particularly consistent with presented medical records.

Presented lumbar radiology verified various abnormalities characterized as "minor" degenerative changes. A degree of "minor" is not particularly indicative of restrictions that would preclude light employment. There was no indication of more serious problems such as stenosis or herniated discs.

Presented hip radiology failed to verify any abnormalities. Petitioner testified her hip pain is verified by an EMG performed in January 2016. An EMG report from January 2016 was not presented.

It is plausible that Petitioner's pain is caused by neurological abnormalities related to her head injury. Petitioner testified she has a neurologist. Neurologist records were not presented.

It is notable that Petitioner alleged she underwent various back and hip treatments (e.g. PT and steroid injections). Petitioner testified she had PT in 2015 for her back and hip. Presented records did not verify Petitioner's attendance at any treatment.

Presented medical records referenced Petitioner may have significant hand arthritis. The diagnosis appeared to be isolated and was not well supported. If reported hand restrictions were supported, employment involving significant hand dexterity (e.g. assembly) would be precluded. The restriction would not preclude the standing or lifting/carrying required of light employment.

Petitioner verified a degree of left should restriction. Petitioner would reasonably be precluded from performing requiring extensive overhead reaching (e.g. stockperson).

Some degree of hip and back pain was verified. The pain was not verified to preclude Petitioner's performance of light employment. Petitioner's verified restrictions might erode some of Petitioner's potential employment base. MDHHS did not present evidence of jobs available to Petitioner. However, jobs within Petitioner's capabilities include cashier, sales clerk, and security guard. The jobs are presumed to be available in sufficient quantity so that Petitioner has a realistic opportunities for employment.

Based on Petitioner's exertional work level (light), age (closely approaching advanced age), education (limited but literate and capable of communicating in English), employment history (unskilled), Medical-Vocational Rule 202.10 is found to apply. This rule dictates a finding that Petitioner is not disabled. Accordingly, it is found that MDHHS properly found Petitioner to be not disabled for purposes of SDA benefits.

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 January 8, 2016, 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]