RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: February 8, 2017
MAHS Docket No.: 16-016955
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 December 21, 2016, from Detroit, Michigan. Petitioner appeared, via telephone, and was unrepresented. 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. 5-10).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Medicaid Eligibility Notice 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 14 days to allow Petitioner to submit a Medical Examination Report and/or other medical documents from a treating neurologist; an Interim Order Extending the Record was subsequently mailed to both parties.

9. Petitioner failed to submit additional medical documents.

10. Petitioner is unable to ambulate effectively due to multiple spinal 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 an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Medical Program Eligibility Notice (Exhibit 1, p. 3) dated October 21, 2016, verifying Petitioner's application was denied based on 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 evidence.

A Medical Source Statement Regarding Residual Functional Capacity (Exhibit 1, pp. 397-401) dated [redacted], was presented. The assessment was completed by an internal medicine physician with an unstated treatment history with Petitioner. Noted diagnoses included HTN, asthma, bilateral CTS, high cholesterol, neural pain, depression, and tendonitis. Petitioner's physician restricted Petitioner to occasional lifting/carrying of 5 pounds. Petitioner's physician stated Petitioner was unable to sustain employment in a competitive environment. A "serious" restriction was placed on Petitioner's ability to maintain regular job attendance.

Various medical records (Exhibit 1, pp. 390-396, 402-475) from 2009-2012 were presented. Treatment for CTS, asthma attack, right arm pain, right foot pain, right back pain, HTN, nervous breakdown, and swallowing difficulty was documented.

A mental status examination report (Exhibit 1, pp. 486- 490) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. The examiner stated Petitioner could perform simple and repetitive activities. An Axis I diagnosis of psychosis was noted. Petitioner's GAF was 51. The examiner stated Petitioner did not answer many of the questions that were asked; the examiner noted Petitioner's effort was questionable. A fair prognosis was noted.

An internal medicine examination report (Exhibit 1, pp. 476-484) dated [redacted] was presented. The report was noted as completed by a consultative physician. Petitioner reported a history of right-side CTS, asthma, right rotator cuff injury, fractured right foot, HTN, and various mental illnesses. It was noted Petitioner used a walker for balance. It was noted Petitioner was unable to tandem walk, toe walk, or heel walk. The examiner stated that clinical evidence supported a need for a walking assistance device. It was noted that Petitioner was able to perform all 23 listed work-related activities (e.g. sitting, standing, lifting, carrying, stooping, bending, and reaching) but each activity was limited due to pain.

Various hospital documents (Exhibit 1, pp. 337-363; 366-387) from May 2012 were presented. On [redacted], it was noted Petitioner reported that voices were telling her to leave the hospital. On [redacted], it was noted Petitioner underwent steroid treatment to combat sepsis related to severe tonsillitis. Discharge diagnoses included acute tonsillitis, neck pain, and dysphagia.

Various pain clinic office visit notes (Exhibit 1, p. 224, 242, 316-318, 326-327) dated [redacted], were presented. It was noted Petitioner was a new patient. The notes stated "wheel chair – because of ankle." It was noted Petitioner underwent an intra-articular right shoulder injection.

A biopsychosocial assessment (Exhibit 1, pp. 156-170) dated [redacted], was presented. The assessment was completed by a social worker from a mental health agency. Petitioner reported her arm was injured in 2008 and that she went "crazy" after her physician did not care about her arm getting fixed. Mental health symptoms included: mood swings, concentration difficulty, poor night sleep, sadness, crying spells, and irritability. Health status was reported as "good". Poor judgment, hallucinations, racing stream of mental activity, flat affect were noted as mental health assessments. Individual counseling, support groups, medications, and reality therapy were recommended.

A lumbar spine MRI report (Exhibit 1, p. 310) dated [redacted], was presented. A disc protrusion with an annular tear was noted at L4-L5. Various disc bulges, without spinal stenosis were noted at L1-L2, from L3 through S1. Facet osteoarthritis was noted at L4-L5 and L5-S1.

A cervical spine MRI report (Exhibit 1, p. 311) dated [redacted], was presented. A Chiari 1 malformation was noted. The diagnosis is indicative of a

neurological disorder causing brain and/or spinal cord compression. The result is that spinal fluid flow may be disrupted. Symptoms are known to often include headaches and a feeling of head pressure.

A letter from a pain clinic physician (Exhibit 1, p. 289) dated [redacted], was presented. Petitioner was diagnosed with chronic pain syndrome.

A Psychiatric Evaluation (Exhibit 1, pp. 148-155) dated [redacted], was presented. The evaluation was performed by a nurse practitioner. Reported symptoms included hallucinations, poor sleep patterns, poor eating patterns, anxiety, crying spells, excessive worry, poor self-control when angered, suicidal ideation, and worrying over health. A flat affect, depressed and anxious mood, adequate impulse control, and adequate judgment were noted. Axis I diagnoses of bipolar disorder I (severe with psychosis) and anxiety disorder were noted. Petitioner's GAF was 40.

Pain clinic documents (Exhibit 1, p. 307) dated [redacted], were presented. It was noted Petitioner underwent an intra-articular right shoulder injection.

Pain clinic documents (Exhibit 1, p. 299-306) dated [redacted], were presented. It was noted Petitioner underwent an epidural steroid injection.

Mental health agency nurse practitioner notes (Exhibit 1, pp. 140-147) dated [redacted], were presented. Petitioner reported she was in too much pain to pick up prescribed medications. Petitioner was noted to be slightly limping. An absence of hallucinations was noted. Cymbalta, Latuda, and Lexapro were continued.

Pain clinic documents (Exhibit 1, p. 291-298) dated [redacted], were presented. It was noted Petitioner underwent an epidural steroid injection.

Mental health agency nurse practitioner notes (Exhibit 1, pp. 134-139) dated [redacted], 2016, were presented. Petitioner reported day sleep. It was noted Petitioner reported that "something is controlling my attitude." Auditory hallucinations were noted. Impulse control and judgment were adequate. Cymbalta, Latuda, and Lexapro were continued.

Primary care physician office visit notes (Exhibit 1, pp. 206-208) dated [redacted], were presented. A complaint of acute blurry vision was noted; treatment was not apparent.

Pain clinic documents (Exhibit 1, p. 290) dated [redacted] were presented. It was noted Petitioner underwent a right shoulder pain injection.

Primary care physician office visit notes (Exhibit 1, pp. 203-205) dated [redacted] were presented. A complaint of dry cough, ongoing for 2 days, was noted.

Pain clinic documents (Exhibit 1, p. 280-286) dated [redacted], were presented. It was noted Petitioner underwent a lumbar facet pain medication injection.

Pain clinic documents (Exhibit 1, p. 268-275) dated [redacted] were presented. It was noted Petitioner received a lumbar facet pain medication injection.

Primary care physician office visit notes (Exhibit 1, pp. 200-202) dated [redacted], were presented. A complaint of eye dryness, ongoing for 5 days, was noted.

Pain clinic documents (Exhibit 1, p. 260-267) dated [redacted], were presented. It was noted Petitioner underwent a right-side lumbar rhizotomy.

Pain clinic documents (Exhibit 1, p. 252-259) dated [redacted], were presented. It was noted Petitioner underwent a left-side lumbar rhizotomy.

Primary care physician office visit notes (Exhibit 1, pp. 197-199) dated [redacted], were presented. Petitioner reported ongoing lumbar pain. A diagnosis of lumbago was noted. Medications were continued.

Physician office visit notes (Exhibit 1, pp. 174-175) dated [redacted], were presented. It was noted that Petitioner complained of right ankle pain (8/10). It was noted Petitioner twisted her ankle 9 months earlier. It was noted Petitioner had no prior treatment. An assessment of right ankle and foot traumatic arthropathy was noted. A plan of padding, strapping, injections, and orthotics was noted. An Unna boot was provided. A recommendation to lose weight was noted. An unspecified injection was provided.

Primary care physician office visit notes (Exhibit 1, pp. 194-196) dated [redacted], were presented. Petitioner reported right foot and ankle pain. An EKG was recommended, though Petitioner refused. It was noted Petitioner needed a referral for further foot treatment. A script for a cane was given. Weight loss was recommended. Petitioner's blood pressure was noted to be high.

Primary care physician office visit notes (Exhibit 1, pp. 191-193) dated [redacted], were presented. Petitioner reported bilateral knee pain, ongoing for 3 days. Lidocaine cream was prescribed.

A Discharge Summary from a mental health agency (Exhibit 1, pp. 132-133) dated [redacted], was presented. It was noted Petitioner attended treatment for a few months before she began cancelling and failing to show for appointments. It was noted Petitioner's difficulty in the cold weather may have contributed to noncompliance.

Primary care physician office visit notes (Exhibit 1, pp. 191-193) dated [redacted], were presented. Petitioner reported bilateral knee pain, ongoing for 3 days. Lidocaine cream was prescribed.

Primary care physician office visit notes (Exhibit 1, pp. 188-190) dated [redacted], were presented. It was noted that Petitioner presented for treatment of right knee pain (ongoing for 1 week) and a birth control shot. Lidocaine cream was prescribed.

A mental status examination report (Exhibit 1, pp.124-127) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. It was noted Petitioner reported no previous psychiatric hospitalizations. Petitioner reported she stopped attending psychotherapy (it was not stated when). Mental status examination assessments included: in-touch with reality, no exaggeration, and logical stream of mental activity. A diagnosis of adjustment disorder (with mixed disturbance of emotions and conduct) was noted. A fair prognosis was noted. It was noted Petitioner was not capable of managing funds due to difficulty with calculations (could not answer 4+7 or 16-9 correctly).

An internal medicine examination report (Exhibit 1, pp. 114-122) dated [redacted], [redacted] was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of back pain, shoulder pain, asthma, rotator cuff injury, HTN, tendonitis, COPD, obesity, depression, and anxiety. Petitioner was noted to be 5'5" tall and weighed 258 pounds. It was noted Petitioner used a wheelchair. It was noted Petitioner was unable to tandem walk, toe walk, or heel walk. Right-sided grip strength was noted to be 2/5. Limited right arm and leg motion was noted. It was noted Petitioner could not support her weight getting up. Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching, though most were performed with pain. The examining physician noted Petitioner had limited, if any use of her right arm due to a shoulder injury. A mental health evaluation was recommended.

Petitioner testified she suffered a right-sided rotator cuff injury in 2007. Petitioner testified it has not been repaired.

Petitioner testified she underwent CTS surgery in March 2007. Petitioner testified she believes the surgeon caused nerve damage and that she is "not the same person" since surgery. Petitioner testified the nerve damage affects her entire right side from the neck down.

Petitioner testified she has a tear in her lower back. Petitioner testified her physician did not recommend surgery due to its uncertain outcome.

Petitioner testified she has mental health problems. Petitioner testified she saw a psychiatrist in December 2015. Petitioner testified she stopped attending therapy appointments after her mother died in January 2016. Petitioner testified she did not think her psychiatrist was helpful. Petitioner testimony implied she has not attempted to see other psychiatrists since quitting psychotherapy.

Petitioner testified she fractured her ankle in the fall of 2015. Petitioner testified she tried to use a cane, but continued falling, including a fall which resulted in burns to Petitioner.

Petitioner testified she is pain all day long. Petitioner testified the pain particularly affects her neck, right knee, and right side of her back. Petitioner testified the pain medication injections have helped a little because now she is able to sit upright.

Petitioner testified she has asthma. Petitioner testified her treatments include a breathing machine.

Presented medical records generally verified a medical treatment history consistent with Petitioner's allegations of restrictions. 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.

Petitioner's primary difficulties appeared to concern ambulation related to various lumbar spine abnormalities. Spinal disorders are covered by Listing 1.04 which reads:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
> OR
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
> OR
> C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

> Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Petitioner testified she had to start using a wheelchair because of repeated falls. Petitioner testified she has used a wheelchair for 3 years.

Petitioner testified she cannot walk. Petitioner testified she is unable to independently stand. Petitioner testimony estimated she could sit 15-20 minutes before back and neck pain required her to lie down.

Petitioner testified she is unable to independently shower as she needs help getting to the shower and sitting down inside of the shower. Petitioner testified she needs help with dressing. Petitioner testified she is incapable of any housework. Petitioner testified she is unable to do laundry, shop or drive. Petitioner testified her days are spent crying, sleeping, and watching television. Petitioner does not expect her condition to improve.

Petitioner's testimony was generally indicative of an inability to ambulate effectively. Presented evidence was mixed concerning the credibility of Petitioner's testimony.

Lumbar radiology from November 2015 verified various lumbar disc bulges, an annular tear, and osteoarthritis. Cervical spine radiology verified a Chiari 1 malformation.

It is possible that verified spinal abnormalities cause Petitioner to experience her symptoms as stated. The possibility increases when factoring a diagnosis of chronic pain syndrome and untreated psychiatric problems.

A Medical Needs form (Exhibit 1, p. 220) dated [redacted], was presented. Petitioner's primary care physician stated a need for assistance with shopping, laundry, and housework. The restrictions were consistent with an inability to effectively ambulate.

A consultative examiner in November 2016 noted significant right-sided grip strength loss, limited arm motion and use of a wheelchair by Petitioner. The statements were consistent with an inability to ambulate effectively. Consideration was given to other statements from the consultative examiner.

The consultative examiner also noted that examiner stated that clinical evidence did not support a need for walking assistance device. Range of motion charts noted no

restriction in right hand, leg, or arm. If accepted, the statements would support rejecting that Petitioner meets the spinal disorder listing. The statements were not persuasive because they conflicted with the narrative statements of the physician. The narrative statements appeared to be more thoughtful than the examiner's statements in range of motion charts. Thus, the physician's conflicting statements are not found to detract from a finding of disability.

It is found Petitioner sufficiently meets the equivalent of Listing 1.04 and is therefore disabled. Substantial evidence of Petitioner's efforts in overcoming disability must be considered.

Petitioner testified she has no full-time work in the previous 15 years. A consultative examiner in 2011 questioned Petitioner's efforts during the mental status examination. Petitioner appears to have serious psychological problems, yet she appeared to voluntarily quit psychotherapy sessions in December 2015. Petitioner failed to provide additional medical records to support her claim despite being told that presented records were possibly sufficient to support her claims of disability. Petitioner appears to have not lost weight despite being regularly advised to do so. All of these considerations are indicative of material noncompliance. Despite substantial evidence questioning Petitioner's efforts in minimizing restrictions, it cannot be stated that total compliance by Petitioner would result in any notable reduction of impairments.

It is found Petitioner is not materially noncompliant in treatment. Accordingly, Petitioner is disabled and it is found that 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]

[redacted]

[redacted]