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

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

Date Mailed: March 17, 2017
MAHS Docket No.: 17-000472
Agency No.:
Petitioner:

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, a telephone hearing was held on , from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by , 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 , Petitioner applied for SDA benefits.

2. Petitioner's only basis for SDA benefits was as a disabled individual.

3. On the Medical Review Team (MRT) determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 2-8), in part, based on a Disability Determination Explanation (Exhibit 1, pp. 9-20).

4. On , MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.
5. On , Petitioner requested a hearing disputing the denial of SDA benefits.

6. As of the date of the administrative hearing, Petitioner was a 50-year-old female.

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

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

9. Petitioner has a history of no relevant employment from the past 15 years which amounted to substantial gainful activity.

10. Petitioner is capable of performing light employment based on restrictions related to dyspnea, cardiac dysfunction, depression, diabetes mellitus (DM), obstructive sleep apnea, fatigue, and hypertension (HTN).

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 did not present a Notice of Case Action, though MDHHS testimony indicated one was mailed on [redacted]. It was not disputed that 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 ████.

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.

Physician office visit notes (Exhibit 2, pp. 124-126) dated ██████████, were presented. It was noted that Petitioner presented for treatment of palpitations, DM, HTN, and hyperlipidemia. A stress echocardiogram from ███████ was noted to be inconclusive. Dyspnea complaints were noted to be NYHA functional classification II. A plan to prescribe verapamil to address HTN was noted.

Physician office visit notes (Exhibit 2, pp. 119-122) dated ██████████ were presented. It was noted that Petitioner reported "severe" fatigue since starting verapamil to control blood pressure. Dyspnea complaints were noted to be NYHA functional classification II. Palpitations were reported. Bilateral peripheral edema was noted. Petitioner's weight was 313 pounds. Lab testing was ordered to evaluate the cause of reported fatigue.

Physician office visit notes (Exhibit 2, pp. 113-117) dated ██████████, were presented. It was noted that Petitioner reported no improvement in fatigue; Ferrous

sulfate dosage was increased. Complaints of dyspnea, vertigo, diarrhea, arthritis, and anemia were noted.

Hospital emergency room documents (Exhibit 2, pp. 138-145) dated [REDACTED], were presented. It was noted that Petitioner presented with complaints of dry cough, ongoing for 3 days. It was noted Petitioner reported improvement after taking various medications. A diagnosis of cough, secondary to bronchitis, was noted.

Physician office visit notes (Exhibit 2, pp. 108-111) dated [REDACTED], were presented. It was noted that Petitioner presented for ongoing treatment for palpitations, HTN, DM, and hyperlipidemia. Dyspnea upon stair climbing was noted; a NYHA functional classification II was assessed. Ankle edema was noted. Current medications included Verapamil, Albuterol, Famotidine, Lyrica, Colace, Metformin, Novolog, Lopid, among others. Cerebrovascular accidents in [REDACTED] were noted. Petitioner's weight was 324 pounds. Petitioner indicated she was scheduled to see a dietician to help eat better. Blood pressure was noted to be controlled. DM was noted to be complicated by neuropathy, and not well controlled. A venous/arterial duplex study was noted to be normal (see Exhibit 2, p. 112).

A mammogram report (Exhibit 2, pp. 135-136) dated [REDACTED], was presented. An impression of no malignancy was noted.

Physician office visit notes (Exhibit 2, pp. 152-160) dated [REDACTED], were presented. It was noted that Petitioner presented for follow-up of HTN. It was noted Petitioner reported 2 hyper-intensive episodes from the previous month. Noncompliance with diet, medications, and weight management were noted. Resolved problems included asthma, HTN, CVA, DVT, bipolar disorder, anemia, and PE. Petitioner's only active problem was obesity. Normal gait and range of motion was noted.

A mental status examination report (Exhibit 2, pp. 98-102) dated [REDACTED], was presented. The report was noted as completed by a consultative licensed psychologist. It was noted Petitioner drove herself to the appointment. It was noted Petitioner reported one previous hospital encounter concerning psychological symptoms. Petitioner reported symptoms of keeping to herself, general depression, and audio hallucinations of her sister. Mental status assessments included logical and goal-directed speech. A diagnosis of depression secondary to multiple medical conditions was noted. A fair prognosis was noted. It was noted Petitioner had difficulty with calculations and was not deemed capable of managing funds, though Petitioner claimed she was capable. The examiner opined Petitioner displayed moderate capacity to concentrate. The examiner stated Petitioner was best suited for simple and repetitive tasks, with little-to-no independent judgment required.

MDHHS presented an undated letter from a sleep apnea center (Exhibit 2, p. 2). The letter informed Petitioner to call her physician by [REDACTED] if she had not received a CPAP machine.

Petitioner testified she sees a foot doctor regularly. Petitioner testified her podiatrist cuts her toenails and shaves her foot callouses. Petitioner testified a doctor performs these functions due to her history of DM.

Petitioner testified she suffered a stroke in 2005. Petitioner testified she thinks the stroke causes her to write and see letters backwards. Petitioner's hearing request included various letters written backwards.

Previous cerebrovascular accidents were documented. In fact, Petitioner appears to have received disability benefits in the past because of the accidents. Ongoing treatment and/or symptoms related to previous strokes was not documented. Due to a lack of evidence, a related severe impairment cannot be found.

Petitioner testified she has regular bouts of vertigo. Petitioner testified she thinks the vertigo is related to a past car accident. A complaint of vertigo was noted. Treatment for vertigo, other than medication, was not apparent. Abnormal brain radiology was not presented. These considerations support rejecting vertigo as a severe impairment.

Petitioner testified she was attending psychotherapy 2 years ago, but stopped after she moved to Wayne County. Petitioner testified she recently attended her first psychiatrist and group therapy appointment since moving. Petitioner testified she was diagnosed with depression and that it causes concentration difficulties.

Psychiatric records were not presented. A consultative examination report documented some degree of judgment and concentration impairment. It is found Petitioner established restrictions related to judgment and concentration.

Petitioner testified she has degenerative disc disease. Petitioner testified she has regular back injections to alleviate pain. Radiology was not presented. A history of various back injections (see Exhibit 2, pp. 155-157) was documented. The history was sufficient to infer some degree of impairment due to back problems.

Petitioner testified she has dyspnea upon exertion. Petitioner testified dyspnea is likely due to obesity and a loss of heart muscle from previous cardiac treatment.

Presented medical evidence sufficiently verified some degree of concentration, judgment, ambulation, standing, and lifting/carrying 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.

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 sleep apnea (Listing 3.10) was considered. The listing was rejected due to a failure to meet the requirements of Listings 3.09 or 12.02.

Cardiac-related listings (Listing 4.00) were considered based on Petitioner's cardiac treatment history. Petitioner failed to meet any cardiac listings.

A listing based on central nervous system vascular accidents (Listing 11.05) was considered based on Petitioner's reported stroke history. The listing was rejected due to a failure to establish motor function disorganization in two extremities or ineffective speech or communication.

A listing for affective disorder (Listing 12.04) was considered based on depression symptoms. 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 reported that she performed data entry employment. Petitioner testified the employment was most recently performed in the 1990s. Petitioner testified she has no earnings from the last 15 years amounting to SGA. Petitioner's testimony was credible and unrebutted.

Without any past, relevant employment history from the last 15 years, it can only be found that Petitioner cannot return to performing such employment. 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 is reliant on a walking-assistance devices. Petitioner testified she uses a cane for short distances and a walker (with a seat) for longer distances.

Petitioner testified she can only walk about a half block before losing her breath. Petitioner testified back pain restricts her standing to 2-3 minute periods. Petitioner testified she can sit for 2-3 hour periods. Petitioner estimated her maximum lifting/carrying weight was 5 pounds.

Petitioner testified she is reliant on a caregiver to assist with daily activities. Petitioner testified she utilizes a chair in the shower. Petitioner testified she is unable to bathe herself due to a limited reach. Petitioner testified she is also needs help with toileting due to reaching limitations. Petitioner testified she is unable to put on a bra. Petitioner

testified she is unable to clean or do laundry. Petitioner testified she can drive. Petitioner she can shop, but is reliant on a scooter.

Petitioner testified she frequently urinates and defecates on herself. Petitioner testified she wears diapers to bed. Petitioner testimony estimated the loss of bowels occurs 4-6 times per month. Petitioner testified this has been ongoing for 6-7 months.

Petitioner’s testimony concerning daily activities was indicative of restrictions that would preclude any employment. Petitioner’s statements of restrictions were so severe, Petitioner seemed closer to nursing care residency than finding employment.

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

An inability to toilet oneself is a problem that would be expected to be documented in medical records. No complaints of bowel or urinary incontinence were documented.

Petitioner’s claim that she was reliant on a cane or walker was compelling evidence of an inability to perform light employment. Evidence for a need for a walking-assistance device was not apparent. Records from [redacted] documented a normal gait. Medical evidence failed to justify any restrictions related to a need for a walking-assistance device or vertigo.

Petitioner established diagnoses of DM, HTN, morbid obesity, and sleep apnea. The diagnoses are either controlled or appear to be uncontrolled due to material noncompliance by Respondent.

Consideration of some degree of impairment due to fatigue was considered. It is notable that Respondent’s complaint of fatigue was not documented following sleep apnea treatment. It is also notable that lab testing ordered to address fatigue was not presented. Petitioner failed to establish fatigue to affect her ability to perform employment.

The most compelling evidence of restriction was a NYHA Class II functional classification. The classification is indicative of cardiac disease resulting in slight limitation of physical activity. Such patients are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain. The classification is fairly consistent with an ability to perform light employment.

Consideration to rejecting the classification was considered because it appeared to be solely based on Petitioner’s reporting of dyspnea. Neither cardiac nor Spirometry testing was presented to justify restrictions.

A diagnosis of neuropathy was indicated. Neurologist treatment was not verified. Neural dysfunction was not apparent in any physical examination. The most recent physician

office visit documented no active diagnoses other than obesity. These considerations were indicative of an ability to perform light employment.

Given established restrictions, Petitioner appears capable of performing light employment requiring modest judgment and/or concentration levels. Such job classification Petitioner could reasonably be expected to perform would include light assembly, cashier, food service, and janitorial employment. MDHHS did not present evidence of employment opportunities available to Petitioner, however, Petitioner's employment opportunities are presumed to be not so limited that ample opportunities are not available.

Findings of Petitioner's functional residual capacity are primarily based on presented medical documents. During the hearing, Petitioner was given the opportunity to submit additional medical documents. Petitioner would not waive her right to a timely hearing decision so that additional medical documents could be submitted. Thus, Petitioner is left primarily with presented medical documents to establish restrictions. Based on presented medical records, it is found Petitioner is capable of performing light employment.

Based on Petitioner's exertional work level (light), age (closely approaching advanced age), education (high school), employment history (none), Medical-Vocational Rule 202.13 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 [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

Petitioner