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: March 31, 2017
MAHS Docket No.: 17-001453
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, a telephone hearing was held on March 1, [redacted] from [redacted] Michigan. Petitioner appeared and was unrepresented. [redacted] Petitioner's ex-wife, testified on behalf of Petitioner. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], manager, and [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 (see Exhibit 1, 1-11).

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

3. On [redacted], the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 6, pp. 1-8).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

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

6. Petitioner has exertional restrictions and injuries sufficient to meet the SSA listing for spinal disorders.

CONCLUSIONS OF LAW

The State Disability Assistance (SDA) program which provides financial assistance for disabled persons is established by 2004 PA 344. MDHHS administers the SDA program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3151-400.3180. MDHHS policies for SDA are found in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Reference Tables Manual (RFT).

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (January 2012), p. 1. A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 7, pp. 1-4) dated [redacted], 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 medical documentation.

Lumbar spine radiology reports (Exhibit 4, pp. 79-83) dated [redacted], was presented. A disc protrusion at L5-S1 was noted to cause nerve root abutment. A disc protrusion at L3-L3 was noted to cause mild nerve root encroachment.

Hospital documents (Exhibit 5, pp. 3-11) dated [redacted] were presented. It was noted Petitioner presented for elective anterior cervical discectomy at C4-C5, C5-C6, and C7. On [redacted], a psychiatric consultation was performed, in part, due to drug-seeking behavior, previous suicidal ideation, and Petitioner's history of alcohol abuse. Axis I diagnoses included alcohol dependence, cannabis abuse, and substance-induced mood disorder. A fair prognosis was noted, with continued treatment and complete abstinence from habit-using drugs.

A cervical spine x-ray report (Exhibit 5, pp. 12-13) dated [redacted], was presented. An impression of s/p cervical spine fusion with no acute abnormalities was noted.

Hospital emergency room documents (Exhibit 5, pp. 16-21) dated [redacted], were presented. It was noted that Petitioner complained of neck pain (10/10) ongoing for [redacted]weeks. An x-ray report indicated stable C4-C7 area was stable. It was noted Petitioner left against medical advice. Acetaminophen was prescribed.

Hospital emergency room documents (Exhibit 5, pp. 26-30) dated [redacted], were presented. It was noted that Petitioner presented for detoxification. It was noted Petitioner was "heavily" intoxicated. It was noted drug testing was positive for marijuana,

amphetamines, and tranquilizers. It was noted that Petitioner left against medical advice.

Hospital emergency room documents (Exhibit 4, pp. 133-140) dated [redacted] were presented. It was noted that Petitioner presented, with his service dogs, with complaints of itchy and swollen legs. Stable dyspnea was reported by Petitioner. Petitioner reported drinking 3 beers and taking valium; it was noted Petitioner "obviously" drank more than he reported. Bilateral pitting edema (+2) was noted. Treatment details were not apparent.

Physician office visit notes (Exhibit 4, pp. 68-70, Exhibit 5, pp. 129-130) dated [redacted], were presented. It was noted Petitioner complained of back pain since a car accident from [redacted] years earlier. It was noted Petitioner's pain was exacerbated by an incident when hospital employees had to forcefully restrain Petitioner; the incident left Petitioner with several broken ribs. A referral to a pain specialist was noted. Urinary frequency was reported. The physician referenced radiology showing multiple herniated cervical spine discs and a torn right shoulder labrum. A CT abdominal report (Exhibit 4, p. 71-74) noted unhealed left-sided rib fractures as a cause of pain.

A cervical spine CT report (Exhibit 4, pp. 75-78) dated [redacted], was presented. It was noted Petitioner was s/p anterior fusion from C4-C7. An impression of superimposed spondylosis resulting in multilevel bilateral foraminal narrowing, worst at C5-C6 was noted. Severe stenosis was noted at C5-C6.

Physician office visit notes (Exhibit 4, pp. 70-71, Exhibit 5, pp. 131-133) dated [redacted], were presented. It was noted Petitioner complained of ongoing neck pain. Pain clinic treatment was planned.

Pain physician office visit notes (Exhibit 4, pp. 60-61, 65-67) dated [redacted], were presented. Petitioner reported 10/10 pain, bilateral arm paresthesia, bilateral leg pain, and spinal pain. Spinal injections were planned. Muscle spasms, reduced reflexes, and slightly reduced motor strength were noted.

Pain physician office visit notes (Exhibit 4, p. 59, 62-64) dated [redacted], were presented. A diagnosis of L5-S1 radiculopathy was noted. It was noted Petitioner underwent cervical spine trigger point injections.

Physician office visit notes (Exhibit 5, pp. 133-134) dated [redacted], were presented. Right shoulder complaints were noted. Full strength and range of motion were noted. It was noted Petitioner's pain was not likely from the shoulder joint. An impression of cervical radiculopathy was noted.

Various physical therapy documents (Exhibit 5, pp. 32-55) from [redacted] through [redacted] were presented. Therapy for neck and right shoulder pain was noted. It was noted Petitioner was discharged, per Petitioner's request, following two treatments.

Physician office visit notes (Exhibit 5, pp. 135-139) dated [redacted], were presented. It was noted that Petitioner complained of ongoing chronic neck and back pain. An EMG was planned.

Spinal physician office visit notes (Exhibit 5, pp. 139-146) dated [redacted] were presented. It was noted Petitioner presented for initial spinal pain treatment. Petitioner reported he had 3 previous spinal pain injections which did not reduce pain.

A neck x-ray report (Exhibit 4, pp. 130-131) dated [redacted], was presented. Mild discogenic changes were noted. Widening of soft tissue was noted to be clinically significant and of uncertain etiology. A CT was noted as considered for the future.

An EMG report (Exhibit 5, pp. 125-127) dated [redacted], was presented. An impression of no evidence of radiculopathy was noted. Changes suggestive of a mild and chronic nerve root irritation at L5 was noted.

Hospital emergency room documents (Exhibit 4, pp. 127-129) dated [redacted], were presented. Petitioner presented and reported he recently fell down a hill and developed left knee and ankle pain. A diagnosis of left ankle abrasion was noted. No infection was noted. Petitioner was discharged without apparent further treatment.

Hospital documents (Exhibit 4, pp. 117-126, Exhibit 5, pp. 99-107) from an admission dated [redacted], were presented. Petitioner reported left foot swelling and pain. “Significant” left edema with mild surrounding erythema was noted. An x-ray was consistent with cellulitis. Mild improvement overnight was noted following medication treatment. At discharge, Petitioner was advised of foot care and medications were prescribed. A follow-up in 7 days was planned. Petitioner was discharged on [redacted]

Hospital emergency room documents (Exhibit 4, pp. 96-116, Exhibit 5, pp. 146-148) dated [redacted], were presented. Petitioner reported a worsening of left foot cellulitis. Bilateral foot erythema was noted. It was noted Petitioner denied drinking, though he had an EtOH level of 111. It was noted that it was not clear if outpatient treatment failed because of infection resistance or medication noncompliance. It was noted Petitioner’s cellulitis improved with medication. It was noted that same-day discharge was not recommended, though Petitioner insisted and promised to follow-up on an outpatient basis on [redacted].

Hospital emergency room documents (Exhibit 5, pp. 70-71) dated [redacted], were presented. It was noted that Petitioner complained of cervical spine pain (6/10). It was noted Petitioner could ambulate without walking assistance, though he carried a cane. Tenderness was noted throughout thoracic paraspinals. A thoracic spine MRI on an outpatient basis was recommended. Gabapentin was prescribed.

Physician office visit notes (Exhibit 5, pp. 72-77) dated [redacted], were presented. It was noted that Petitioner complained of cervical spine pain (6/10). It was noted Petitioner's EtOH level was 111. Edema and pain improved after medication. A thoracic spine MRI report noted moderate canal stenosis (see Exhibit 5, p. 124).

Hospital emergency room documents (Exhibit 5, pp. 56-64) dated [redacted], were presented. It was noted that Petitioner was brought by ambulance for a psychiatric evaluation. It was noted Petitioner screamed and threatened violence. Petitioner was eventually placed in restraints. Ketamine was injected. It was noted Petitioner was eventually discharged. Discharge diagnoses included "reaction to severe stress", restlessness and agitation, and alcohol abuse with delirium.

Hospital emergency room documents (Exhibit 4, pp. 92-95) dated [redacted], were presented. Petitioner reported "something was wrong" with his head and that his "thinking [was] not right." Ongoing foot pain was noted. It was noted Petitioner was found to be intoxicated. It was noted Petitioner left while an IV was still attached. It was noted security was called and Petitioner was returned and underwent foot wound care. It was noted Petitioner was denied a request for pain medication.

Pain physician office visit notes (Exhibit 4, pp. 56- 58) dated [redacted], were presented. Reported pain back, knees, legs, and hips was reported. Straight-leg-raising testing was positive. Various medications were prescribed.

A pulmonary function report (Exhibit 4, pp. 90-91) dated [redacted], was presented. An impression of normal spirometry was noted.

Psychiatrist office visit notes (Exhibit 2, pp. 27-34) dated [redacted], were presented. It was noted that Petitioner presented for initial treatment. Reported symptoms included mood swings, depression, sleep difficulty, reduced appetite, fatigue, lack of energy, difficulty comprehending, and irritability. It was noted Petitioner reported a troubled childhood including being the victim of sexual and physical abuse. Mental status assessments included constricted affect, depressed mood, linear thought process, and impaired recent memory. Diagnoses were not noted. Lamotrigine was prescribed.

Pain physician office visit notes (Exhibit 4, p. 52) dated [redacted], were presented. A diagnosis of L5-S1 radiculopathy was noted. It was noted Petitioner underwent an epidural steroid injection. An 80% decrease in pain was reported.

Hospital emergency room documents (Exhibit 5, pp. 78-80) dated [redacted], were presented. It was noted that Petitioner presented with complaints of worsening dyspnea. A history of cigarette smoking and CHF was noted. Outpatient treatment with a pulmonologist was recommended.

Hospital emergency room documents (Exhibit 1, pp. 81-84) dated [redacted], were presented. It was noted that Petitioner presented with complaints of cervical and thoracic spine pain. Gabapentin was increased. A physical therapy referral was recommended.

Psychiatrist office documents (Exhibit 4, pp. 2-11) dated [redacted], were presented. Presented notes appeared to repeat the office visit notes from September 23, 2016.

A Mental Residual Functional Capacity Assessment (Exhibit 4, pp. 28-45) dated [redacted], was presented. The assessment was signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate limitations to understanding and remembering information, carrying out detailed instructions, maintaining attention, and interacting appropriately were noted. Petitioner was deemed capable of performing simple and repetitive work.

Petitioner presented a list of medications (Exhibit A, pp. 1-2), active as of [redacted] Medications included albuterol Sulfate, Alprazolam, Diazepam, Ibuprofen, Meloxicam, Metoprolol, Hydrocodone,-Acetaminophen, Trazodone, and others.

Petitioner testified that he injured his back when a "buddy" playfully pushed him out of a 3-story window while they worked together. Petitioner's caretaker and wife testified Petitioner was actually pushed out of a window by his sister when Petitioner was a toddler.

Petitioner testified he has memory loss from the incident. Petitioner testified he sometimes forgets what he is saying. Petitioner testified he also forgets to eat. Petitioner testified he is not responsible enough to take his own medication. Petitioner's caretaker testified Petitioner is very forgetful; as an example, she testified Petitioner has left on the stove after using it. Petitioner also testified he also struggles with comprehending and reading.

Petitioner testified he regularly has seizures. Petitioner testified he's had them his entire life. Petitioner testified he has a service dog who helps him come out of seizures. Petitioner testified his dog also helps him to remember to take medications. Petitioner testified his last seizure occurred approximately 1 ½ months before the hearing.

Petitioner testified he uses a cane or wheelchair at all times (Petitioner brought a cane to the hearing). Petitioner testified he tends to use a wheelchair in nicer weather.

Petitioner testified he has recurring problems with falling. Petitioner testimony estimated that he has fallen at least 12 times in the 3 months before the hearing. Petitioner testified some of the falls occurred while using a cane, some did not.

Petitioner testified he was diagnosed with COPD and asthma. Petitioner testified he uses a breathing machine at home. The testimony was not consistent with presented Spirometry test results.

Petitioner testified he needs help with bathing because he is at risk for falling. Petitioner testified he needs help putting on socks and shoes. Petitioner also testified dressing makes him short in breath. Petitioner testified his caretaker/wife does all housework though he can make simple meals for himself. Petitioner testified he cannot shop because walking is painful. Petitioner testified he is unable to drive due to seizures. Petitioner's caretaker testified Petitioner is getting worse and "can hardly" do anything for himself. She further testified that she stays with Petitioner 4-5 hours in the evening and that she is afraid to leave Petitioner. As an example, she once arrived to find Petitioner lying helplessly on the floor. Petitioner testified he used to hunt and fish, but can no longer do so.

Petitioner testified he has attempted to find employment, though he would need an accommodation of periodic rest. Petitioner testified he was unable to find an accommodating employer.

Petitioner testified he has previous employment as a laborer for a nursery; Petitioner testified the employment required regular lifting/carrying of 50-60 pounds. Petitioner testified he also worked with trees and was expected to lift 100+ pound logs. Petitioner testified he is currently limited to lifting/carrying of a maximum of 10 pounds.

Presented medical records verified cervical spine dysfunction consistent with exertional restrictions. A degree of psychiatric dysfunction can be inferred from several incidents documented in Petitioner's history, though ongoing treatment was not verified. 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 most prominent impairment appears to be back pain due to multiple spinal problems. 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 he has a “very, very hard time” with stairs. Petitioner testified he can only walk a block due to his spinal problems. Petitioner testified he can only sit for 15 minutes due to losing his breath, Petitioner testimony estimated he can sit for 20 minutes before needing to stand. Petitioner testified his lifting/carrying is restricted to 10 pounds or less.

Petitioner’s caretaker testified Petitioner needs help traveling stairs. As an example, she testified it took 30 minutes for Petitioner to climb 10-15 steps on the day before the hearing; on a better day, she said it would take Petitioner 10-15 minutes.

Presented testimony was indicative of meeting SSA listing requirements. Presented medical records were mixed in whether Petitioner’s meets SSA listing requirements.

A Physical Residual Functional Capacity Assessment (Exhibit 4, pp. 20-27) dated [redacted], was presented. The assessment appeared to be completed by a “single decisionmaker” as part of Petitioner’s SSA claim of disability. Stated restrictions included occasional lifting of 20 pounds, frequent ability to lift/carry 10 pounds, standing or walking at least 2 hours in an 8 hour workday, sitting about 6 hours of an 8 hour workday, unlimited pushing/pulling, occasional kneeling, occasional crawling, and

occasional crouching. Considerations included a normal gait, abnormal EMG, and decreased range of motion.

The assessments from SSA staff were not indicative of meeting listing requirements for spinal disorders. Generally, assessments from a non-physician, particularly one with no personal history of treating a petitioner, will not be given much consideration.

The most insightful evidence of meeting listing requirements was that radiology verified *severe* cervical spinal stenosis. Generally, severe stenosis is consistent with severe restrictions. It is particularly notable that the stenosis followed previously performed fusion surgery. Though a reduction in pain was verified following a steroid injection, such injections are known only to temporarily relieve pain, rather than correct the underlying cause. It is likely that Petitioner's pain relief was temporary as PT was later ordered. It is also notable that Petitioner's cervical spine pain appears to be aggravated by psychological dysfunction and unhealed broken ribs.

It is found Petitioner sufficiently meets the equivalent of the listing for spinal disorders. Typically, such a finding directly results in a finding of disability. One further consideration is necessary in Petitioner's case.

When drug and/or alcohol abuse (DAA) is applicable, SSA applies the steps of the sequential evaluation a second time to determine whether the petitioner would be disabled if he or she were not using drugs or alcohol. SSR 13-2p. It is a longstanding SSA policy that the claimant continues to have the burden of proving disability throughout the DAA materiality analysis. *Id.* Noted considerations made by SSA concerning drug materiality include the following:

- Does the claimant have DAA?
- Is the claimant disabled considering all impairments, including DAA?
- Is DAA the only impairment?
- Is the other impairment disabling by itself while the claimant is dependent upon or abusing drugs and/or alcohol?
- Does the DAA cause or affect the claimant's medically determinable impairments?
- Would the other impairments improve to the point of non-disability in the absence of DAA

Generally, behavior and observation from a hearing are not relevant. Petitioner's behavior garnered sympathy from MDHHS staff; it was also suspicious for intoxication.

MDHHS testimony indicated Petitioner seemed "out of it" and that he could barely keep his head upright. They further testified witnessing Petitioner needing a cane and guidance from his caretaker. Further observations indicated Petitioner was shaking and that he fell asleep during a point in the hearing. The workers also expressed concern over Petitioner falling out of his chair. A MDHHS specialist also testified that she's witnessed Petitioner's poor memory by having to re-explain something she just said.

Petitioner testified he quit drinking "a little over a year ago." The testimony was inconsistent with hospital statements indicating Petitioner was drunk in [redacted].

Though Petitioner may be an ongoing alcoholic despite testimony to the contrary, Petitioner's possible alcoholism would not alter the likely restrictions resulting from severe spinal stenosis and unhealed ribs. Material noncompliance of alcoholism (or repeated departures against medical advice) is not deemed to be alter the finding of disability.

It is found Petitioner is a disabled individual. Accordingly, it is found 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/

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]