RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Mailed: March 31, 2017
MAHS Docket No.: 17-001840
Agency No.:
Petitioner:

**ADMINISTRATIVE LAW JUDGE: Eric J. Feldman**

## HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 6, 2017, from Detroit, Michigan. Petitioner was present for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by , Eligibility Specialist.

## ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

## 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 September 26, 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On or about December 29, 2016, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program. Exhibit A, pp. 7-13.

3. On January 9, 2017, the Department sent Petitioner a Notice of Case Action denying the application effective October 16, 2016, based on DDS/MRT's finding of no disability. Exhibit A, pp. 4-5.

4. On January 20, 2017, the Department received Petitioner's timely written request for hearing. Exhibit A, pp. 2-3.

5. Petitioner alleged disabling impairments due to carpal tunnel syndrome, cervical disc herniation, arthritis, pinched nerve, fingers number, high blood pressure/cholesterol, vision problems, neck and arm pain, heart issues, and depression/anxiety.

6. On the date of the hearing, Petitioner was 55 years old with a date of birth of [redacted] [redacted] she was 5'5" in height and weighed 165-170 pounds.

7. Petitioner is a high school graduate.

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

9. Petitioner has an employment history of work as a server/waitress.

10. Per the credible testimony of the Petitioner, she has a pending appeal for a disability claim with the Social Security Administration.

## CONCLUSIONS OF LAW

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

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has

the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

**Step One**

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, she is not ineligible under Step 1 and the analysis continues to Step 2.

**Step Two**

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR

416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. SSR 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.;* SSR 96-3p.

In the present case, Petitioner alleges disabling impairments to carpal tunnel syndrome, cervical disc herniation, arthritis, pinched nerve, fingers number, high blood pressure/cholesterol, vision problems, neck and arm pain, heart issues, and depression/anxiety. The medical evidence presented at the hearing was reviewed and is summarized below.

On ██████████ Petitioner had a Magnetic Resonance Imaging (MRI) of her cervical spine, which resulted in the following impressions: (i) C5-C6 – broad-based disc osteophyte, as with a superimposed right foramina protrusion resulting in moderately severe right and mild left neural foramina stenosis; there is flattening and effacement of ventral thecal sac abutting the ventral aspect of the cord narrowing the anteroposterior (AP) diameter of the canal is 8 mm; (ii) C6-C7 – diffuse disc bulge flattening and effacing the ventral thecal sac abutting the ventral aspect of the cord mild right to moderate and moderate left neural foramina stenosis, mild facet hypertrophy; (iii) C7-T1 – diffuse disc bulge with a superimposed left foramina protrusion measuring 3 mm in AP dimension with associated hyperintense T2 signal abnormality, concerning for annular tear, severe left neural foramina stenosis; and (iv) straightening of the normal cervical lordosis could be secondary to patient positioning versus muscle spasm, moderate disc

height loss and desiccation at C5-C6 and at C6-C7 with mild endplate spurring and a degenerative endplate marrow changes. Exhibit A, pp. 33-34.

On [redacted], Petitioner saw her doctor complaining of neck pain, headaches, left shoulder and arm pain, numbness/tingling bilateral arm and hand pain. Exhibit A, pp. 41-42. An examination by the doctor revealed her head, ears, eyes, nose, and throat is normal. Exhibit A, p. 42. The doctor noted carotid pulsations are normal bilaterally and there are no bruits, her neck is supple, good range of motion and there is no spasm or tenderness. Exhibit A, p. 42. The doctor noted examination of the thoracic region and lumbar region is normal, range of lumbar spine is normal, and straight leg raising is negative bilaterally. Exhibit A, p. 42. Her neurologic examination shows Petitioner to be awake, alert, and oriented with good mention. Exhibit A, p. 42. The doctor mentioned the MRI results and his impression is degenerative changes in the cervical spine and possible carpal tunnel. Exhibit A, p. 42.

On [redacted], Petitioner had lab results showing her triglycerides are higher than what the doctor would like to see and fasting blood glucose is also elevated which means at risk for developing diabetes. Exhibit A, p. 30.

On [redacted], Petitioner saw her doctor complaining of the same symptoms. Exhibit A, p. 47. The doctor noted that Petitioner has no acute distress, her mental status is intact, cranial nerves are intact, an electromyogram (EMG) of the upper extremities performed on [redacted], revealed mild to moderate left median nerve neuropathy at the wrist, resulting in a diagnosis of left carpal tunnel syndrome. Exhibit A, p. 47.

On [redacted], Petitioner had a vision examination because she was complaining of blur at a distance and near in both eyes, and complains of film over vision in both eyes for 6 months. Exhibit A, p. 54. The diagnosis of her exam revealed (i) myopia (nearsightedness) and (ii) astigmatism and the plan was to get new glasses prescribed to correct visual acuity and function. Exhibit A, p. 55.

On [redacted], Petitioner saw her Physical Therapist (PT) for a Physical Therapy Initial Evaluation because she was referred due to a spinal stenosis of cervical region. Exhibit 1, p. 7. It was noted that her aggravating factors/limitation include looking up, turning head and relieving factors include avoid movement. Exhibit 1, p. 7. Also, a Physical Therapy Daily Note dated [redacted], indicated that Petitioner had deficits in decreased arm, pain and weakness in the neck, shoulder and the assessment of Petitioner found that she did not tolerate assessment or traction well, she does not drive, so she has to rely on someone else to take her so her attendance will be minimal and sporadic, too soon to indicate whether there is improvement and she needs continued physical therapy due to neck pain and disc disease. Exhibit 1, pp. 9-10.

On [redacted], Petitioner saw the doctor regarding her admitting diagnosis of depression with suicidal thoughts. Exhibit 1, p. 4.

On [redacted], Petitioner saw the doctor and diagnosed her with the following: (i) major depression recurrent, severe, in partial remission, generalized anxiety disorder, alcohol dependence; (ii) degenerative disc disease, chronic back pain, dyslipidemia; and she had a Global Assessment of Functioning (GAF) score of 45. Exhibit 1, p. 4.

On [redacted], Petitioner had a transthoracic echocardiogram, which found the following: (i) left ventricular ejection fraction, by visual estimation, is 60 to 65%; (ii) borderline concentric left ventricular hypertrophy; (iii) impaired relaxation pattern of left ventricle (LV) diastolic filling; and (iv) mild aortic value sclerosis without stenosis. Exhibit 1, pp. 12-13.

A [redacted], Petitioner had a carotid doppler performed, which diagnosed her with minimal hard and soft atheromatous plaque at the carotid bifurcation bilaterally somewhat more on the left compared to right; hemodynamically there is mild stenosis close to 50% in the origin of the left internal carotid artery (ICA) and mild atherosclerotic stenosis at the origin of the external carotid artery (ECA) is bilaterally, hemodynamically no significant stenosis at the origin right ICA; and antegrade flow is seen the vertebral arteries bilaterally. Exhibit 1, p. 11. Also, her doctor reviewed the carotid doppler and indicated it “looks good” and there is no evidence of any significant blockage of blood flow to the brain. Exhibit 1, p. 14.

On [redacted], the doctor indicated that both a cholesterol and blood glucose tests are a little bit higher than he would like to see, elevated blood glucoses are risks for developing diabetes, the elevated cholesterol risk for stroke and heart disease, and neither one need treatment with medicine at the moment. Exhibit 1, pp. 15-16.

On undated lab report in which the doctor’s office indicated all lab reports look good. Exhibit 1, p. 17 (Petitioner wrote that it was collected on [redacted]). Petitioner also presented other lab reports for glucose fasting. Exhibit 1, pp. 18-21.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

**Step Three**

Step 3 of the sequential analysis of a disability claim requires a determination if the individual’s impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual’s impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint(s) (due to any cause)), 1.04 (disorders of the spine), 4.00 (cardiovascular system), 12.04 (affective disorders), and 12.06 (anxiety-related disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

**Residual Functional Capacity**

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b).

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.*; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner alleges disabling impairments due to carpal tunnel syndrome, cervical disc herniation, arthritis, pinched nerve, fingers number, high blood pressure/cholesterol, vision problems, neck and arm pain, heart issues, and depression/anxiety. She testified that she thinks she will faint, and she is limited in her neck and shoulder movement. She always feel weak and fatigued. She could not use her arms without there being sharp pain. She testified she cannot lift a gallon of milk. She can stand for no more than 10 minutes. She can sit for 10 to 15 minutes. She can walk up to 1 to 2 blocks. She is able to dress/undress herself, bathe/shower, go grocery shopping, but difficulty in completing chores. She says she needs support with walking, including going up the stairs. She also indicated she has blockage in her arm. She indicated that she suffers from depression. She testified that she was admitted to the hospital on or about ██████████, and a petition was signed for her to go to the hospital to treat her mental conditions. She has a hard time concentrating if she is

overwhelmed and trouble working with others. It should be noted that Petitioner testified that she does not trust her primary doctor.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

On , Petitioner had a MRI of her cervical spine, in which the findings included moderate disc height loss and desiccation at C5-C6 and at C6-C7 with mild endplate spurring and a degenerative endplate marrow changes. Exhibit A, p. 33. On , her doctor concluded that she had carpal tunnel syndrome based on an EMG performed on . Exhibit A, p. 47. On , Petitioner's sought treatment from her PT for joint pain due to a medical diagnosis of spinal stenosis of cervical region. Exhibit 1, p. 7. The PT noted Petitioner's deficits included decreased arm, pain and weakness in the neck and shoulder. Exhibit 1, p. 9. On a doctor diagnosed her with degenerative disc disease and chronic back pain. Exhibit 1, p. 4. Also, on , Petitioner had a carotid doppler performed and her doctor reviewed the findings and indicated there was no evidence of any significant blockage of blood flow to the brain. Exhibit 1, p. 13. Petitioner also had a vision examination performed on , which diagnosed her with (i) myopia (nearsightedness) and (ii) astigmatism and the plan was to get new glasses prescribed to correct visual acuity and function. Exhibit A, p. 55. This evidence was sufficient to support Petitioner's allegation of carpal tunnel syndrome, finger numbness, and neck, back, arm and shoulder pain.

On , Petitioner saw the doctor regarding her admitting diagnosis of depression with suicidal thoughts. Exhibit 1, p. 4. On , Petitioner was also diagnosed by the doctor with major depression recurrent, severe, in partial remission, generalized anxiety disorder, alcohol dependence; and she had a GAF score of 45. Exhibit 1, p. 4. Therefore, Petitioner also has a medical diagnosis supporting her symptoms of depression and anxiety.

With respect to the intensity, persistence and limiting effects of her symptoms, the medical evidence included an MRI of her cervical spine, and progress notes from her doctor, which indicated degenerative changes in her cervical spine and that she had left carpal tunnel syndrome. Exhibit A, pp. 33 and 42. On , Petitioner sought treatment from her PT, who noted her deficits included decreased arm, pain and weakness in the neck and shoulder. Exhibit 1, p. 9. Also, on , Petitioner had another doctor who diagnosed her with degenerative disc disease, chronic back pain, and dyslipidemia. Exhibit 1, p. 4. These findings support Petitioner's statement that she has numbness in the fingers (carpal tunnel syndrome) and pain in the neck, back, arm, and shoulder. But, with respect to the intensity, persistence and

limiting effects of her symptoms, she is capable of performing light work. On [redacted], Petitioner alleged the same disabling impartments when she saw her doctor. Exhibit A, pp. 41-42. An examination by her doctor revealed her head, ears, eyes, nose, and throat is normal. Exhibit A, p. 42. The doctor noted carotid pulsations are normal bilaterally and there are no bruits, her neck is supple, she has a good range of motion and there is no spasm or tenderness. Exhibit A, p. 42. The doctor noted an examination of her thoracic region and lumbar region is normal, range of lumbar spine is normal, straight leg raising is negative bilaterally, he could not detect a Tinel's sign over any peripheral nerves of either upper or lower extremity, and Phalen's maneuver is negative bilaterally. Exhibit A, p. 42. These findings by her doctor, along with the medical evidence presented for the record, do not show Petitioner is limited to perform less than light work (i.e., sedentary). In fact, Petitioner indicated during the hearing that she able to dress/undress herself, bathe/shower, go grocery shopping, prepare her own meals (slowly), and drive a car, but has not driven a car for a while.

Accordingly, the undersigned Administrative Law Judge (ALJ) finds that based on a review of the entire record, including Petitioner's testimony, the evidence was sufficient to establish that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

With respect to Petitioner's nonexertional limitations, the medical evidence was less extensive. As stated above, Petitioner testified that she was admitted to the hospital on or about [redacted], and a petition was signed for her to go to the hospital to treat her mental conditions. The undersigned ALJ reviewed the medical evidence and found documentation that was most likely related to her hospital visit. On [redacted], Petitioner saw a regarding her admitting diagnosis of depression with suicidal thoughts. Exhibit 1, p. 4. Also, on [redacted], Petitioner was also diagnosed by the doctor with major depression recurrent, severe, in partial remission, generalized anxiety disorder, alcohol dependence; and she had a GAF score of 45. Exhibit 1, p. 4. It appears this was her discharge diagnoses from the hospital. Petitioner further indicated that she suffers from depression and she has a hard time concentrating if she is overwhelmed and trouble working with others. However, there was no other medical evidence presented, other than the above two documents, which addressed her nonexertional limitations. The undersigned ALJ finds that the medical evidence was limited as to Petitioner's nonexertional limitations.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild limitations to her activities of daily living; mild limitations to her social functioning; and mild limitations to her concentration, persistence or pace.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

**Step Four**

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id.*; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a server/waitress. Petitioner's work as a server/waitress required light physical exertion and was considered semi-skilled work experience. See Exhibit A, pp. 10 and 27 (Dictionary of Occupational Titles (DOT) – Strength category and Specific Vocational Preparation (SVP) rating).

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than light work activities and she has mild limitations in her mental capacity to perform basic work activities. In light of the entire record and Petitioner's RFC, including her mental limitations, it is found that Petitioner is able to perform past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

## DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner not disabled for purposes of the SDA benefit program.

Accordingly, the Department's determination is **AFFIRMED**.

EF/tm

**Eric J. Feldman**
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**

cc: