STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: May 3, 2017
MAHS Docket No.: 17-002790
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 29, 2017, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator.

ISSUE

The issue is whether MDHHS properly denied Petitioner's State Disability Assistance (SDA) eligibility for the reason that Petitioner is not a disabled individual.

FINDINGS OF FACT

The administrative law judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On [redacted], Petitioner applied for SDA benefits.

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

3. On [redacted], the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 18-24), in part, based on a Disability Determination Explanation (Exhibit 1, pp. 25-39).

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

7. As of the date of the administrative hearing, Petitioner was a 60-year-old female.

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

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

10. Petitioner has knee dysfunction which precludes the performance of medium employment.

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).

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 1, pp. 18-24) dated [redacted], [redacted], verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally

defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA eligibility]. 20 CFR 416.905.

SGA means a person does the following: performs significant duties, does them for a reasonable length of time, and does a job normally done for pay or profit. *Id*., p. 9. Significant duties are duties used to do a job or run a business. *Id*. They must also have a degree of economic value. *Id*. The ability to run a household or take care of oneself does not, on its own, constitute SGA. *Id*.

The person claiming a physical or mental disability has the burden to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CFR 413.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a).

Federal regulations describe a sequential five step process that is to be followed in determining whether a person is disabled. 20 CFR 416.920. If there is no finding of disability or lack of disability at each step, the process moves to the next step. 20 CFR 416.920 (a)(4).

The first step in the process considers a person's current work activity. 20 CFR 416.920 (a)(4)(i). A person who is earning more than a certain monthly amount is ordinarily considered to be engaging in SGA. The monthly amount depends on whether a person is statutorily blind or not. The 2016 monthly income limit considered SGA for non-blind individuals is $1,130.00.

Petitioner credibly denied performing current employment; no evidence was submitted to contradict Petitioner's testimony. Based on the presented evidence, it is found that Petitioner is not performing SGA. Accordingly, the disability analysis may proceed to the second step.

The second step in the disability evaluation is to determine whether a severe medically determinable physical or mental impairment exists to meet the durational requirement. 20 CFR 416.920 (a)(4)(ii). The impairments may be combined to meet the severity requirement. If a severe impairment is not found, then a person is deemed not disabled. *Id*.

The impairments must significantly limit a person's basic work activities. 20 CFR 416.920 (a)(5)(c). "Basic work activities" refers to the abilities and aptitudes necessary to do most jobs. *Id.* Examples of basic work activities include:

- physical functions (e.g. walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling)
- capacities for seeing, hearing, and speaking, understanding; carrying out, and remembering simple instructions
- use of judgment
- responding appropriately to supervision, co-workers and usual work situations; and/or
- dealing with changes in a routine work setting.

Generally, federal courts have imposed a de minimus standard upon petitioners to establish the existence of a severe impairment. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005); *Hinkle v. Apfel*, 132 F.3d 1349, 1352 (10th Cir. 1997). *Higgs v Bowen,* 880 F2d 860, 862 (6th Cir. 1988). Similarly, Social Security Ruling 85-28 has been interpreted so that a claim may be denied at step two for lack of a severe impairment only when the medical evidence establishes a slight abnormality or combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work even if the individual's age, education, or work experience were specifically considered. *Barrientos v. Secretary of Health and Human Servs.*, 820 F.2d 1, 2 (1st Cir. 1987). Social Security Ruling 85-28 has been clarified so that the step two severity requirements are intended "to do no more than screen out groundless claims." *McDonald v. Secretary of Health and Human Servs.*, 795 F.2d 1118, 1124 (1st Cir. 1986).

SSA specifically notes that age, education, and work experience are not considered at the second step of the disability analysis. 20 CFR 416.920 (5)(c). In determining whether Petitioner's impairments amount to a severe impairment, all other relevant evidence may be considered. The analysis will begin with a summary of presented medical documentation.

Hospital emergency room documents (Exhibit 1, pp. 298-308) dated [redacted], were presented. It was noted that Petitioner presented with a left-eye laceration after being hit with a coffee cup. Eye radiology was negative. Petitioner's eye was sutured.

Hospital emergency room documents (Exhibit 1, pp. 309-352) dated [redacted], were presented. It was noted that Petitioner complained of worsening dyspnea and radiating back pain. Pneumonia was diagnosed. Petitioner was kept overnight and treated with various medications. Straight-leg-raise testing was negative. Lumbar spine x-rays noted degenerative changes. A lumbar MRI report noted multiple disc bulges. An impression of moderate spondylosis causing mild neural foraminal narrowing was noted.

Hospital emergency room documents (Exhibit 1, pp. 192-193) dated [redacted], [redacted], were presented. It was noted that Petitioner complained of high blood pressure. It was noted Petitioner was in rehab for crack cocaine and alcohol addictions and that she

had not felt well since starting rehab. A complaint of left knee pain was also noted. Knee swelling was noted to be likely from a Baker's cyst. Lisinopril was prescribed. Follow-up for knee at a low-cost clinic was recommended.

Hospital emergency room documents (Exhibit 1, pp. 194-198) dated [redacted] were presented. It was noted that Petitioner presented with leg pain (4/10). Normal gait and strength were noted. An ultrasound was negative for deep vein thrombosis (DVT). A plan of orthopedic follow-up was noted.

Hospital emergency room documents (Exhibit 1, pp. 199-201) dated [redacted], were presented. It was noted that Petitioner presented with complaints of left knee pain, ongoing for a month. It was noted x-rays demonstrated cystic changes of the lateral femoral condyle. Naprosyn was prescribed for pain.

Hospital emergency room documents (Exhibit 1, pp. 202-206) dated [redacted], were presented. It was noted that Petitioner presented for HTN and psychiatric med refills.

Hospital emergency room documents (Exhibit 1, pp. 207-211) dated [redacted], were presented. It was noted that Petitioner complained of a runny nose and hacking cough. A diagnosis of upper respiratory infection was noted.

Hospital emergency room documents (Exhibit 1, pp. 254-267) dated [redacted], were presented. It was noted that Petitioner complained of right-knee pain. Mild spurring was indicated by radiology. Norco was prescribed for pain. A right knee strain was diagnosed.

Hospital emergency room documents (Exhibit 1, pp. 363-391) dated [redacted] were presented. It was noted that Petitioner presented after a slip-and-fall on ice. Hypoxia and dyspnea were also noted. Radiology demonstrated rib fractures (9 and 10). Outpatient treatment was planned for pancreas problems. Discharge diagnosis included pneumonia. A discharge date of [redacted], was noted.

Hospital emergency room documents (Exhibit 1, pp. 268-278) dated [redacted], were presented. It was noted that Petitioner complained of a swollen right knee. A full range of motion for the knee was noted. An x-ray indicated a joint effusion. Petitioner's knee was wrapped. Prednisone and naproxen were prescribed.

Hospital emergency room documents (Exhibit 1, pp. 279-297) dated [redacted], were presented. It was noted that Petitioner complained of bilateral knee pain, ongoing for months. Difficulty with ambulation was reported. Minor arthritic changes were noted in a left-knee x-ray report. Suprapatellar effusion was noted in right-knee x-ray reports. A right knee wrap was applied before discharge.

Primary care physician (PCP) office visit notes (Exhibit 1, pp. 243-245) dated [redacted], were presented. It was noted Petitioner was "feeling well." Ongoing treatment for back pain, HTN, and anxiety was noted. Various medications were prescribed.

PCP office visit notes (Exhibit 1, pp. 241-242) dated [redacted], were presented. Ongoing treatment for back pain and anxiety was noted. A diagnosis of arthritis was noted; Naproxen, Lidocaine, and Cyclobenzaprine were prescribed. Anxiety medication was also prescribed.

PCP office visit notes (Exhibit 1, pp. 239-240) dated [redacted], were presented. It was noted Petitioner presented for a wellness exam. No complaints were noted.

A Psychiatric Evaluation (Exhibit 1, pp. 393-396) dated [redacted], was presented. Reported symptoms included sadness, hopelessness, decreased energy, decreased appetite, anhedonia, racing thoughts, forgetfulness, poor concentration, loss of libido, audio hallucinations, and video hallucinations. It was noted Petitioner last used crack cocaine 90 day earlier. Mental status assessments included unremarkable appearance, unremarkable motor status, anxious mood, unremarkable memory, fair judgment, fair insight, and unremarkable thought process. A diagnosis of schizoaffective disorder was noted. Petitioner's GAF was 50. A plan of unspecified medication treatment was noted.

PCP office visit notes (Exhibit 1, pp. 233-238) dated [redacted], were presented. It was noted Petitioner was "feeling well." Ongoing treatment for back pain, HTN, and anxiety was noted. Various medications were prescribed.

PCP office visit notes (Exhibit 1, pp. 230-232) dated [redacted], were presented. Ongoing treatment for back pain, HTN, and anxiety was noted. Naproxen and lidocaine were continued for back pain. Atenolol was continued for HTN. Cyclobenzaprine was prescribed for acute back spasms. Xanax was prescribed for anxiety.

PCP office visit notes (Exhibit 1, pp. 227-229) dated [redacted], were presented. Ongoing treatment for back pain, right ankle pain, HTN, and anxiety was noted. Various medications were continued.

Hospital emergency room documents (Exhibit 1, pp. 142-148) dated [redacted], were presented. It was noted that Petitioner presented with complaints of constipation. It was noted that Petitioner had "good results" following an enema.

Hospital emergency room documents (Exhibit 1, pp. 149-171) dated [redacted], were presented. It was noted that Petitioner presented with complaints of knee pain and dyspnea. Chest radiology was negative. It was noted Petitioner was a smoker.

PCP physician office visit notes (Exhibit 1, pp. 355-357) dated [redacted], were presented. Various medications were prescribed for bronchitis, HTN, depression, and right-knee pain.

Hospital emergency room documents (Exhibit 1, pp. 172-186) dated [redacted], were presented. It was noted that Petitioner presented with complaints of a twisted ankle following a slip. Radiology demonstrated a small displaced fracture.

Sports medicine physician office visit notes (Exhibit 1, pp. 123-126, 131-137) dated [redacted], were presented. It was noted that Petitioner reported as a new patient with a complaint of bilateral-knee pain. It was noted x-rays (Exhibit 1, pp. 127-130) showed “obliteration” of lateral joint space on the right side. “Advanced degenerative” disease was noted on the right. A diagnosis of bilateral knee arthritis was noted. A plan of lidocaine injections, pain meds, and PT was noted. A follow-up in 4 weeks was planned.

A mental status examination report (Exhibit 1, pp. 112-116) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Petitioner reported a history of schizoaffective disorder. Petitioner reported no previous hospitalizations, and treatment that stopped due to a lack of transportation. Petitioner reported recent difficulty due to homelessness. Petitioner reported recent social isolationism. Noted observations of Petitioner made by the consultative examiner includes adequate contact with reality. Petitioner reported she sometimes gets messages from the television or radio. It was noted Petitioner showed slight-to-moderate strength in immediate memory, recent memory, and attentiveness. It was opined Petitioner could perform simple and repetitive tasks requiring minimal judgment. A guarded prognosis was noted.

Petitioner testified she has chronic back pain. Petitioner testified she tried PT approximately 14-15 years earlier, but it was not effective in reducing pain. Petitioner testified she has not attempted steroid injections.

Petitioner testified she has chronic knee pain. Petitioner testified she tried injections about a year ago, though she did not have further injections because she developed a headache from them. Petitioner testified she should have knee replacement surgery.

Petitioner testified she has COPD. Petitioner testimony implied she has increased breathing difficulty with exertion. Respiratory testing was not presented. Notable treatments (e.g. breathing treatments) were not apparent. It is also relevant that Petitioner testimony conceded she is an ongoing half a pack/day smoker. Petitioner failed to verify impairments related to COPD.

Much of Petitioner’s presented documents involved acute problems. Treatments for an eye laceration, constipation, a right-knee strain, and a cold were documented. These problems were not verified to last 90 days or longer and will not be further considered.

The presented psychiatric evaluation was indicative of degrees of significant psychological dysfunction. Numerous symptoms were documented, most notably, hallucinations and a diagnosis of schizoaffective disorder. The evaluation was consistent with impairments to concentration.

A significant portion of Petitioner's treatment was from 2015 and older. Petitioner's older treatments may be relevant if the problems persist. Complaints of lumbar pain and right knee pain were documented throughout presented documents. The problems would reasonably restrict Petitioner's ability to ambulate and lift/carry.

Presented medical records were indicative of restrictions to concentration, ambulation and lifting/carrying. Petitioner's 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 joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

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 schizophrenia (Listing 12.03) was considered based on a diagnosis of schizoaffective disorder. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner' diagnosis was "serious and persistent." Most notably, Petitioner failed to demonstrate any psychiatric intervention outside of a single evaluation. Petitioner's symptoms are presumably stable based on medication prescribed by her primary-care physician.

It is found that Petitioner failed to establish meeting (or equaling) an SSA listing. Accordingly, the analysis moves to the fourth step.

The fourth step in analyzing a disability claim requires an assessment of the Petitioner's residual functional capacity (RFC) and past relevant employment. 20 CFR 416.920(a)(4)(iv). An individual is not disabled if it is determined that a petitioner can perform past relevant work. *Id*.

Past relevant work is work that has been performed within the past 15 years that was a substantial gainful activity and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1). Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy is not considered. 20 CFR 416.960(b)(3). RFC is assessed based on impairment(s), and any related symptoms, such as pain, which may cause physical and mental limitations that affect what can be done in a work setting. RFC is the most that can be done, despite the limitations.

Petitioner testified her only work since 2002 involved part-time work as a chore service provider. Petitioner testified her employment since 2002 involved approximately 12 hours/week. Presumably, the employment was not for SGA earnings; thus, it cannot be factored in the analysis.

Petitioner testified she worked full-time in 2001-2002 as a direct care worker. Petitioner testified her duties involved bathing, dressing, feeding, and lifting patients. Petitioner testified she quit her job because of the difficulty in lifting patients. Petitioner testimony implied she is still unable to perform the lifting/carrying required of her past employment.

Petitioner's testimony that she is unable to perform the lifting/carrying required of past employment was credible and consistent with Petitioner's treatment for knee and lumbar pain. It is found Petitioner cannot perform past relevant employment and 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 medium 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. Medium employment requires

comparable standing and walking standards, but with a heavier lifting requirement than light employment.

Petitioner testified she does not use a walking-assistance device. Petitioner testified 4-5 stairs is her limit before she needs to rest. Petitioner testified dyspnea and knee pain limit her walking to 1 block. Petitioner testified she can only stand for 5-10 minutes due to leg pain. Petitioner estimated her sitting is limited to 30 minutes, presumably due to back pain. Petitioner testified her gripping and grasping is fine, though she testified her hands sometimes cramp.

Petitioner testified she can bathe and dress herself. Petitioner testified she has to pace herself when performing housework, shopping, and laundry. Petitioner testified she uses a scooter when shopping.

Petitioner's testimony was indicative of an inability to perform the lifting/carrying or ambulation required of medium employment. The analysis will consider whether Petitioner's testimony were verified by presented medical records.

Required use of a cane is highly indicative of an inability to perform medium employment. Though Petitioner testified she relied on a cane, a need for a cane was not apparent in presented records.

Knee pain was documented over several years. Most notably, "advanced" knee degeneration was documented shortly after Petitioner applied for SDA benefits. The diagnosis was significant enough to justify numerous treatments including PT, injections, and pain medication. The treatment was highly indicative of an inability to perform medium employment.

It is found Petitioner is not capable of performing light employment due to nee dysfunction. For purposes of this decision, it will be assumed that Petitioner can perform the requirements of light employment.

Based on Petitioner's exertional work level (light), age (advanced age), education (limited or less), employment history (unskilled), Medical-Vocational Rule 202.01 is found to apply. This rule dictates a finding that Petitioner is disabled. Accordingly, it is found that MDHHS improperly 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 improperly denied Petitioner's application for SDA benefits. It is ordered that MDHHS begin to perform the following actions within 10 days of the date of mailing of this decision:

(1) reinstate Petitioner's SDA benefit application dated [redacted];

(2) evaluate Petitioner's eligibility subject to the finding that Petitioner is a disabled individual;
(3) initiate a supplement for any benefits not issued as a result of the improper application denial; and
(4) schedule a review of benefits in one year from the date of this administrative decision, if Petitioner is found eligible for future benefits.

The actions taken by MDHHS are **REVERSED**.

CG/hw

Christian Gardocki
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS [redacted]

Petitioner [redacted]