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: July 17, 2017
MAHS Docket No.: [redacted] 17-005064
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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. After due notice, a telephone hearing was held on [redacted], from Detroit, Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by [redacted], Eligibility Specialist and [redacted], Family Independence Manager.

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 [redacted], the Petitioner submitted an application seeking cash assistance on the basis of disability SDA.

2. On [redacted], 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 [redacted], the Department issued a Notice of Case Action denying the Petitioner's application for SDA effective [redacted], based upon DDS/MRT's finding of no disability. Exhibit A, pp. 1-3.

4. On [redacted], the Department received Petitioner's timely written request for hearing. Exhibit A, p. 2.

5. Petitioner has alleged disabling impairment due to right rotator cuff tear, pancreatitis, kidney disease, essential tremor right hand and a history of thyroid cancer in remission.

6. On the date of the hearing, Petitioner was 58 years old with a [redacted], birth date; he is 5' 7" in height and weighs about 147 pounds.

7. Petitioner earned a GED and received an auto tech certification with the State of Michigan in 1983.

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

9. The Petitioner has an employment history of work as a truck fleet maintenance and repair mechanic and supervised 3 other mechanics. The Petitioner also worked on buses in a prior job. The Petitioner last worked in 2012.

10. The Petitioner has home help care provider services provided by the Department.

11. Petitioner has a pending disability claim on appeal 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. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least 90 days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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, he 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.

The medical evidence presented at the hearing, *and* in response to the interim order, was reviewed and is summarized below.

On [redacted], the Petitioner had an MRI of the right shoulder rotator cuff. The results noted that the Petitioner had an 11mm (approximately ½ inch) linear rim rent tear of the supraspinatus tendon with tendinopathy. The Petitioner was scheduled for a repair surgery but no surgery had occurred at the time of the hearing.

A Medical Exam Report was completed on [redacted] by Petitioner's family practice medical doctor who first examined him in [redacted]. The report was provided pursuant to the Interim Order issued in this case. The current diagnosis was abdominal pain and alcoholic pancreatitis, hypertension, hypothyroidism, essential tremors, dyslipidemia, toxic hepatitis and history of thyroid cancer. The physical exam noted Petitioner is right hand dominant, with chronic left shoulder pain, and essential tremors. Range of motion was limited in right shoulder. The exam notes smoking half pack a day. The notes indicate that patient has essential tremors and is significantly depressed and Petitioner's condition was noted as deteriorating.

The following limitations were imposed which were anticipated to last more than 90 days. Lifting occasionally, with left arm only, up to10 pounds and no lifting of 20 pounds or more. The Petitioner could perform simple grasping with both hands and could only reach, push/pull and fine manipulate with the left hand. The Petitioner could stand and/or walk about 2 hours in an 8 hour workday and there were no limitations on operating foot/leg controls. He could sit less than 6 hours in an 8 hour work day.

The doctor found that the Petitioner could not meet his activities of daily living including washing, shopping, laundry and cleaning. Additional mental limiations were imposed

with regard to comprehension, memory, sustained concentration, reading and writing and social interaction. The findings and limitations were based upon the doctor's examination of his patient. The Petitioner did not allege any mental impairment in the application and did not present any evidence that he has received treatment for any mental disorder.

On [redacted], the Petitioner was seen in the emergency room for complaint of a fall in an assault. The Petitioner had been drinking at the time and had an argument, was pushed and fell down 3 stairs. He was able to ambulate after the fall, did not lose consciousness. The pain was described as coming and going with no associated numbness or weakness, a dull ache. The Petitioner was examined and was not in acute distress. There was tenderness to the lumbar spine midline, but no step-offs felt and no obvious C spine tenderness. The diagnosis notes indicate acute tendonitis of right shoulder and alcohol induced hepatitis.

On [redacted], the Petitioner was admitted to the hospital for severe mid abdominal stomach pain. The Petitioner was admitted for a two day stay and was noted in serious condition when admitted. Petitioner presented with the following history, alcohol abuse, hyperlipidemia, hypothyroidism, thyroidectomy and GERD. Pain was reported as sever 10/10. The Petitioner was discharged with a primary diagnosis of pancreatitis secondary to alcohol abuse and leukocytosis secondary to pancreatitis. The Petitioner's discharge condition was improved. The main treatment was for pancreatitis secondary to alcohol abuse.

On [redacted], the Petitioner was evaluated at the request of his treating family physician by a neurologist in regards to tremor of the right hand. The examiner found that based upon the patient's symptoms, the diagnosis was essential tremor. Also found was well identified peripheral neuropathy, both large and small fiber. The MRI revealed chronic matter disease, consistent with his history of smoking, cholesterol, diabetes, and being male. The examiner recommended smoking cessation, diabetes management and daily aspirin due to possible cardiac problems with syncopal incidents of dizziness. The examiner noted a cardiac work-up being deemed important. In a prior exam on [redacted], the neurologist ruled out Parkinson's disease and also identified peripheral neuropathy, both large and small fiber, as well as right carpal tunnel syndrome.

The Petitioner's treating family practice doctor's progress notes were also reviewed. The notes begin in [redacted] The notes for [redacted] indicate that the Petitioner was almost tremor free. The notes further indicate that "patient was told again to stop intake of any etoh (alcohol) of any kind. The diagnosis for that visit indicates essential tremors, high blood pressure, renal insufficiency, alcohol abuse, hypothy, and pancreatitis. The notes further indicate that on [redacted] Petitioner was seen with complaints of some respiratory issues and tremor in his right hand. Diagnosis was essential tremor, COPD, alcohol withdrawal, seizures, and ETOH liver disease. Prednisone was started for tremors. Tremors were 80 percent improved.

Notes indicate that Petitioner was seen at hospital due to passing out at home in [redacted] for two days. Many of the notes were unreadable.

The Petitioner was admitted to the hospital on [redacted] for dizziness and lightheadedness. At the time of admission renal failure was noted and the patient reported 3 episodes the previous day which led to falls. Last drink noted as one week ago. At the time of admission the Petitioner was a smoker and reported he used to drink 1 pint a day with the last drink one week ago. At the time of admission the impression and plan noted near syncope secondary to orthostatic hypotension. Acute kidney injury with significant prerenal factors. A final report noted near syncope secondary to orthostatic hypotension. Patient admitted in [redacted] with similar complaints. Patient left against medical advice because he felt better and he knew what was wrong with him. Renal ultra sound was normal. Marijuana use was also noted. The admission noted serious condition due to dehydration and renal failure. Final impression was acute near syncopal episode, acute chronic renal failure and acute leukocytosis.

The Petitioner was admitted to the hospital on [redacted] After diagnostic testing, the chest results showed no acute process; ultra sound of abdomen impression was Cholelithiasis not acute, mild increase in echogenicity of liver, may indicate mild diffuse hepatocellular disease. A renal ultrasound was also completed which determined medical renal disease with normal size kidneys and no hydronephrosis evident. Another CT of pancreas noted calcification of the pancreatic head, suggesting chronic pancreatitis. A CT of the neck with note history of thyroid cancer detected no mass and no enlarged cervical lymph nodes. A CT of thorax (throat) noted no metastatic pulmonary nodules with mild emphysematous lung changes are seen bilaterally. There was no pleural effusion or pneumothorax. The heart was not enlarged, no pericardial effusion. The impression for the CT of the thorax was no metastatic pulmonary nodules or enlarged thoracic lymph nodes identified. The record also indicated a diagnosis of chronic kidney disease with consideration of hemodialysis in near future. The Final Report was acute oliguric renal failure, pancreatitis secondary to alcohol abuse, thyroid cancer, status post thyroidectomy, tremors secondary to possible alcohol abuse and dyslipidemia.

On [redacted], the Petitioner's daughter assisted him in completing an Activities of Daily Living form. The form indicates that due to tremors, in the hand, the Petitioner does not cook, clean and has difficulty dressing. The Home Care provider assists with cooking, shopping for groceries, laundry and cleaning. The form also indicates that the Petitioner does not use sharp objects because of his hand tremors. The form also notes that due to a history of passing out, Petitioner does not perform chores.

An Activities of Daily Living also was completed separately by Petitioner's daughter based on her own observations on [redacted] The form notes that standing and walking are limited and right hand tremor is present. Prior to his illnesses the Petitioner could cook, write, wash clothes, go to the doctor and drive there. The

Petitioner also could clean his own home. There is a note that he cannot tie shoes due to tremors or shave due to cutting himself. The Petitioner does no work around his house, inside or out. The Petitioner is noted as right handed. The form further notes the following are affected by his illness: lifting, walking, bending, stair climbing, kneeling, reaching, squatting, using hands, and standing. The answers also indicate that the Petitioner can walk a half block only. The form indicates that at the time the Petitioner was drinking alcohol all the time. The Petitioner is having symptoms due to medications that affect him causing tiredness, hair loss, mental and mood change and headaches.

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, listing 11.14 peripheral neuropathy was considered and requires that the disorganization of a motor function had to be present in two extremeties and result in an extreme limitation in the use of the upper extremeties. Based upon the Petitioner's treating physician's evaluation the listing was not met as the Petitioner has the use of his right hand for simple grasping, and full use of the left hand. Listing 6.03 chronic kidney disease was also reviewed but was not met as the listing requires chronic hemodialysis. The Petitioner has medically established kidney disease however does not receive hemodialysis. Therefore, 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 and thus the Petitioner is not found disabled at Step 3 and the analysis must proceed 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).

In this case, Petitioner alleges exertional limitations arising from his essential tremors and shoulder pain due a torn rotator cuff. Although the Petitioner's treating doctor noted mental limitations, no testing or treatment of same has occurred. At the hearing, the Petitioner testified that he could stand approximately 10-15 minutes and could walk 3 blocks and then his thighs got tight. The Petitioner could sit all day. Due to his right hand tremors he could not put tooth paste on his tooth brush, had to sit to put on his pants and has trouble grasping with his right hand things such as a screwdriver due to tremors. The Petitioner does not drive and has a home help care provider who cleans, does laundry, grocery shopping and driving. The Petitioner does not do laundry because he cannot carry the laundry basket. The Petitioner also uses a cane as a walking aid.

The Petitioner's treating doctor who has seen him since 2001 also imposed limitations. Lifting was limited to the use of the left arm only, lifting occasionally up to 10 pounds and no lifting of 20 pounds or more. The Petitioner could perform simple grasping with both hands and could only reach, push/pull and fine manipulate with the left hand/arm. The Petitioner could stand and/or walk about 2 hours in an 8 hour workday and there were no limitations on operating foot/leg controls. He could sit less than 6 hours in an 8 hour work day.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a) due to limitations with respect to his right hand tremor and right shoulder rotator tear and pain in the shoulder.

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 by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) 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) and (2). 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 truck fleet maintenance and repair mechanic and supervision of 3 other mechanics. The Petitioner also worked as a repair and maintenance mechanic on buses in a prior job. The Petitioner last worked in 2012.

This job required standing all day and lifting frequently up to 50 pounds and moving large truck tires when performing maintenance. Some of the batteries he was required

to lift weighed up to 100 pounds and some of the equipment he had to lift or manipulate weighed 50 - 100 pounds. The job required standing/walking at least 7 hours in an 8 hour work day and lifting and carrying parts and tools much of the day. In addition the Petitioner was required to kneel, crouch, and handle, grab, and grasp big objects such as engine parts. He was also required to complete written reports.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. In light of the entire record, it is found that Petitioner's exertional RFC prohibits him from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). 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*).*

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, 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). When a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969 a(d).

In this case, Petitioner was 57 years old at the time of application, and 58 years old at the time of hearing, and, thus is considered to be advanced age (age 55 and over) for purposes of Appendix 2. He has a GED and an auto tech certification since 1983. Petitioner has a history of work experience as semi skilled/skilled work. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and

continuing basis to meet the physical demands to perform sedentary work activities. Based on his exertional RFC, age, education, and lack of transferrable skills, the Medical-Vocational Guidelines, 201.06, result in a finding that Petitioner **is** disabled.

Because the Petitioner has a documented medical history of alcohol abuse, the analysis must consider whether the alcohol abuse is material. After a review of the record, it is determined that alcohol abuse is not material. The following evidence was considered. Due to the Petitioner's ongoing tremors in his right dominant hand with limitations in the use of that hand, his current right shoulder rotator cuff tear, as well as his multiple hospitalizations for pancreatitis even without drinking alcohol and his medically established medical renal disease (last admission noting dialysis may be necessary in the future), there was no evidence presented to conclude that Petitioner's conditions would improve if he no longer abused alcohol such that he would no longer be disabled.

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 disabled for purposes of the SDA benefit program.

Accordingly, the Department's determination is REVERSED.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process the Petitioner's [redacted] SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination.

2. Supplement Petitioner for lost benefits, if any that Petitioner was otherwise entitled to receive if eligible and qualified.

3. The Department shall review this case in [redacted].

LMF/tlf

Lynn M. Ferris
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

Via Email: [redacted]

Petitioner – Via First-Class Mail: [redacted]