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 25, 2017
MAHS Docket No.: 17-006544
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 June 19, 2017, from Detroit, Michigan. Petitioner appeared and was unrepresented. [redacted], Petitioner's spouse, testified on behalf of Petitioner. 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 (see Exhibit 1, pp. 3-23).

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. 33-39).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits.

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 32-year-old female.

8. Petitioner has multiple psychological symptoms causing marked impairments to social function and concentration.

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 an 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. 577-580) dated May 1, 2017, 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 2015), p. 1. A person is disabled for SDA purposes if he/she:

- Receives other specified disability-related benefits or services… 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., pp. 1-2.

[State agencies] must use the same definition of disability as used under SSI… 42 C.F.R. § 435.540(a). [Federal] law defines disability as the inability to do any substantial gainful activity 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. 20 C.F.R. § 416.905(a). MDHHS adopted a functionally identical definition of disability (see BEM 260 (July 2015), p. 10). The same definition applies to SDA, though SDA eligibility requires only a 90-day period of disability.

In general, you have to prove… that you are blind or disabled. 20 C.F.R. § 416.912(a). You must inform [MDHHS] about or submit all evidence known… that relates to whether or not you are blind or disabled. *Id*. Evidence includes, but is not limited to objective medical evidence e.g. medical signs and laboratory findings), evidence from other medical sources (e.g. medical history and opinions), and non-medical statements about symptoms (e.g. testimony) (see *Id*.).

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

The first step in the process considers a person's current work activity (see 20 C.F.R. §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.

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*.

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 C.F.R. §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 C.F.R. §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 C.F.R. § 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.

A cervical spine x-ray report (Exhibit 1, p. 187) dated [redacted], was presented. An impression of cervical lordosis straightening and intact disc spaces was noted.

Various physician office visit notes (Exhibit 1, pp. 123-138, 247-248) from 2015 were presented. Diagnoses of lumbago and anxiety were regularly noted. Various medications including Norco, lidocaine gel, Ventolin (for asthma), and Klonopin, and others were regularly prescribed. It was regularly noted that Petitioner was a daily smoker.

A Psychological Report (Exhibit 1, pp. 482-485) dated [redacted], was presented. The report was signed by a limited-licensed psychologist and cosigned by a licensed psychologist. Petitioner reported mental health symptoms of insomnia, flashbacks, nightmares, hallucinations, hypervigilance, social isolationism, racing thoughts, crying spells, and daytime sleep. Petitioner reported recurrent difficulty with coworkers at various jobs. Petitioner reported not drinking alcohol since 2012. Petitioner reported a history of victimization of sexual abuse. It was noted Petitioner struggled with abstract thought. Diagnoses included bipolar disorder (type 1), PTSD, and anxiety disorder. Individual counseling was recommended.

A lumbar MRI report (Exhibit 1, pp. 173-174) dated [redacted], was presented. Degenerative disc disease at L5-S1 causing mild bilateral neural foraminal stenosis was noted. It was noted there were no neural impingements.

An abdominal MRI report (Exhibit 1, pp. 165-166, 170-171) dated [redacted], was presented. An impression of multiple liver lesions requiring follow-up was noted.

Various PCP office visit notes (Exhibit 1, pp. 222-246) from January 2015 through May 2015 were presented. A total of approximately 20 encounters were documented, including 10 from April 2016.

Hospital emergency room documents (Exhibit 1, pp. 365-383) dated [redacted], were presented. It was noted that Petitioner presented with complaints of nausea and diarrhea, ongoing for one day. Petitioner reported she might be going through narcotic withdrawal. A physical exam was unremarkable. Non-narcotic medication was prescribed.

Physical therapy documents (Exhibit 1, pp. 268-274) dated [redacted], were presented. Discharge documents indicated Petitioner was unable to perform goals of recreational activities, ADLs, or work activities due to reported pain.

Hospital emergency room documents (Exhibit 1, pp. 384-402) dated [redacted], were presented. Petitioner presented after waking-up with hives and mild eye swelling. Various meds were administered and hives improved. A discharge diagnosis of urticaria was noted.

A lumbar MRI report (Exhibit 1, pp. 163-164, 402-408) dated [redacted], was presented. Minimal nerve root contact causing mild central canal stenosis at L5-S1 was noted. No other stenosis was noted.

Bloodwork results (Exhibit 1, pp. 409-416) dated [redacted], were presented. No analysis was provided.

Primary care physician (PCP) office visit notes (Exhibit 1, pp. 220-221) dated [redacted] were presented. Petitioner underwent a toradol injection to address back pain.

PCP office visit notes (Exhibit 1, pp. 219-220) dated [redacted], were presented. Petitioner underwent a toradol injection to address back pain.

PCP office visit notes (Exhibit 1, pp. 218-219) dated [redacted], were presented. Gynecological issues were noted.

PCP office visit notes (Exhibit 1, pp. 214-215) dated [redacted], were presented. Petitioner reported increased back pain. It was noted Petitioner increasingly used a wheelchair for ambulation. Petitioner underwent a toradol injection to address back pain. Various meds were updated.

PCP office visit notes (Exhibit 1, pp. 214-215) dated [redacted], were presented. Petitioner underwent a toradol injection to address back pain.

PCP office visit notes (Exhibit 1, pp. 213-214) dated [redacted], were presented. It was noted Petitioner requested klonopin instead of valium for depression and anxiety. A shower chair prescription was noted. Various meds were updated.

PCP office visit notes (Exhibit 1, pp. 212-213) dated [redacted], were presented. It was noted Petitioner received a toradol shot in response to back pain.

Physician assistant office visit notes (Exhibit 1, pp. 168, 422-437) dated [redacted], were presented. It was noted that Petitioner complained of lumbar pain. A lumbar x-ray report noted mild scoliosis.

PCP office visit notes (Exhibit 1, pp. 209-211) dated [redacted], were presented. Assessments included lumbago and chronic pain syndrome. Various medications were continued. A left-hip x-ray was planned in response to a complaint of pain.

PCP office visit notes (Exhibit 1, pp. 208-209) dated [redacted], were presented. Ongoing back pain was reported. It was noted Petitioner stopped attending physical therapy (PT) due to pain. A 30-day supply of Norco was prescribed.

Physician office visit notes (Exhibit 1, pp. 141-142, 249-264, 503-508) dated [redacted] were presented. It was noted that Petitioner complained of lumbar pain. Positive straight-leg raising was noted. Spinal tenderness was noted. Continued physical and occupational therapy was noted. Pain medications were also continued. Smoking cessation was recommended.

A nerve conduction study report (Exhibit 1, pp. 265-267) dated [redacted], was presented. An impression of lumbosacral radiculopathy and left superficial peroneal neuropathy was noted.

PCP office visit notes (Exhibit 1, pp. 207-208) dated [redacted], were presented. Ongoing back pain was reported. It was noted Petitioner stopped attending OT due to pain complaints. Ongoing use of a shower chair, TENS unit, and back brace were noted. A toradol injection was performed. Various medications were continued.

Physician office visit notes (Exhibit 1, pp. 162, 443-448) dated [redacted], were presented. It was noted that Petitioner complained of left-hip pain. A hip x-ray report was negative.

Hospital emergency room documents (Exhibit 1, pp. 41-53, 449-475) dated [redacted], were presented. It was noted that Petitioner presented with complaints of mild abdominal pain. Petitioner was given a GI cocktail and Protonix injection before discharge.

Anesthesiologist office visit notes (Exhibit 1, pp. 54-71, 281-282) dated [redacted], were presented. Petitioner reported back pain. Reported treatments included use of a TENS unit several times per day, various pain medications, and lying on side. It was noted that Petitioner underwent an epidural steroid injection.

PCP office visit notes (Exhibit 1, pp. 205-206) dated [redacted], were presented. Petitioner reported for Norco and asthma med refills. It was noted Petitioner's pain was stable using current medications. Asthma was noted to be controlled.

Anesthesiologist office visit notes (Exhibit 1, pp 283-300) date [redacted], were presented. reported improvement in pain following first injection until [redacted]. A second epidural lumbar injection was performed.

PCP office visit notes (Exhibit 1, pp. 203-205) dated [redacted], were presented. Petitioner reported stable symptoms while taking Klonopin. Klonopin and other medications were refilled and/or continued.

PCP office visit notes (Exhibit 1, pp. 202-203) dated [redacted], were presented. It was noted Petitioner presented for Norco refills after recent spinal injection wore-off.

Hospital emergency room documents (Exhibit 1, pp. 300-339) dated [redacted], [redacted] were presented. It was noted that Petitioner complained of lower abdominal pain, ongoing since that morning, and constipation. Petitioner reported she had IBS or Crohn's disease (she was not sure which). Abdominal radiology was negative. Mild abdominal tenderness was noted. Lab 1work was ordered. Petitioner was discharged with generic abdominal pain instructions.

PCP office visit notes (Exhibit 1, pp. 200-202) dated [redacted], were presented. It was noted Petitioner was not attending counseling "as she should." Petitioner reported spine injections work well, though only temporarily. Various medications were continued and/or adjusted.

Physician office visit notes (Exhibit 1, pp. 509-511) dated [redacted], were presented. Ongoing back pain was reported. A plan of a L5-S1 microdiscetomy was noted.

PCP office visit notes (Exhibit 1, pp. 199-200) dated [redacted], were presented. Norco was prescribed for back pain. An antalgic gait was noted. Trazodone was prescribed for reported insomnia. A shower chair and back brace were noted to be discontinued for the reason of "Course Complete".

Orthopedist office visit notes (Exhibit 1, pp. 340-357, 498-501, 512-513) dated [redacted], were presented. It was noted that Petitioner underwent L5-S1 microdisk surgery to relieve compression. No complications were apparent.

Physician office visit notes (Exhibit 1, pp. 509-511) dated [redacted], were presented. Back and leg pain was reported following a long walk. The pain was attributed to Petitioner's increase in activity. Percocet was prescribed.

Medical center encounter documents (Exhibit 1, pp. 81-101) dated [redacted], were presented. Petitioner presented for medication refills following surgery. Petitioner reported ongoing back pain despite recent surgery. Seizure treatment from a car accident in 2005 was noted in Petitioner's medical history. Petitioner reported Percocet was unhelpful. A referral to an occupational therapist was requested. Lumbar flexion and extension motions were reduced. It was noted Petitioner ambulated without pain. Clonazepam and naproxen were prescribed. Bipolar medications were also prescribed.

Post-surgery physician office visit notes (Exhibit 1, pp. 495-497, 502) dated [redacted], were presented. Petitioner reported manageable back pain. A lumbar x-ray report (Exhibit 1, pp. 358-360) indicated minimal post-surgery disc space thinning was noted at L5-S1. Oxycodone was prescribed.

A letter from a social worker (Exhibit 1, p. 479) dated [redacted], was presented. It was stated Petitioner began participating in mental health and substance abuse treatment in 2013. It was noted Petitioner periodically attended sessions through 2016.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 521-528) dated [redacted], was presented. The assessment was signed by a consultant physician as part of Petitioner's SSA claim of disability. Stated restrictions included occasional lifting of 20 pounds, frequent ability to lift/carry 10 pounds, standing or sitting about 6 hours in an 8-hour workday, unlimited pushing/pulling, occasional kneeling, occasional crawling, and occasional crouching. The stated basis for assessments was lumbar pathology and office visit noted dated [redacted].

Presented records noted various treatment for gastro-intestinal problems. Petitioner testified she was diagnosed with Crohn's disease, and that she can deal with it. Petitioner's testimony did not imply any impairments related to digestive problems.

Petitioner testified she has recurring seizures. Petitioner testified she's had 3 seizures in the last 30 days. Petitioner testified one particular seizure in the last 6 months caused her to lose consciousness for an hour.

Petitioner testified she has used a wheelchair since July 2016. Petitioner testified she did not use a wheelchair on the day of hearing.

Petitioner testified she has impairments due to lumbar pain. Petitioner testified her lumbar problems are related to a pinched nerve in her left leg. Petitioner testified she has a permanent limp in her left leg due to muscle loss. Petitioner testified she is currently attending physical and occupational therapy; Petitioner testified the therapy worsens her pain. Petitioner could not explain why she attends therapy if it does not help. Petitioner testified pain injections and surgery have not reduced her pain. Petitioner testified she is considering spinal fusion surgery.

Petitioner testified her walking was limited to "a couple blocks." Petitioner estimated her standing was limited to 5-10 minutes. Petitioner testified she could "sit for a while";

Petitioner estimated she could sit 6 of 8 hours. Petitioner testified she is unable to lift/carry more than a gallon of milk.

During the hearing, Petitioner was asked if she could perform sit-down employment for an 8-hour workday. Petitioner expressed doubt that she could stay awake for 8 hours and further stated that she takes 4-5 hour naps. Petitioner also indicated that the stress of working with people could drive her to murder.

Petitioner testified she has bilateral hand tremors. Petitioner testified the tremors are caused by anxiety. Petitioner testified she tries to use breathing techniques to control her anxiety.

Petitioner testified she can shower but relies on a shower chair. Petitioner testified that she needs assistance with dressing, particularly with putting on underwear and shoes. Petitioner testified she tries to help with housework by sweeping or doing dishes. Petitioner testified she is physically unable to remove clothes from a clothes dryer. Petitioner testified she can shop and take the bus.

Petitioner testified she attended psychological counseling back in 2010. Petitioner testified she sees a psychiatrist every 2 weeks and a counselor every 2 weeks.

Petitioner testified her history included about 10 attempts of suicide, though a hospitalization never followed. Petitioner testified she last attempted suicide in 2016.

Petitioner testified she stabbed her husband in 2012. Petitioner's husband functionally corroborated the testimony, though his testimony indicated the incident may not have been as serious as the testimony sounded.

Presented records were indicative of degrees of lifting/carrying and ambulation restrictions based on spine dysfunction. Presented records were also indicative of degrees of impairments to social interaction and concentration. Petitioner's treatment history for impairments 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 C.F.R. § 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

Petitioner's primary basis for disability was based on psychological symptoms, worsened by physical pain. Anxiety-like symptoms were routinely reported by Petitioner. The relevant listing for anxiety disorders reads as follows:

12.06 Anxiety and obsessive-compulsive disorders (see 12.00B5), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:
    1. Anxiety disorder, characterized by three or more of the following;
        a. Restlessness;
        b. Easily fatigued;
        c. Difficulty concentrating;
        d. Irritability;
        e. Muscle tension; or
        f. Sleep disturbance.
    2. Panic disorder or agoraphobia, characterized by one or both:
        a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or
        b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).
    3. Obsessive-compulsive disorder, characterized by one or both:
        a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts; or
        b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):
    1. Understand, remember, or apply information (see 12.00E1).
    2. Interact with others (see 12.00E2).
    3. Concentrate, persist, or maintain pace (see 12.00E3).
    4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
    1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and
    2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

Presented medical documents sufficiently documented Petitioner’s complaints of irritability, sleep disturbance, and concentration difficulties. It is found Petitioner meets Part A of the above listing. Presented assessments will be considered in determining if Petitioner meets Part B of the listing for anxiety disorders.

A Psychiatric Review Technique and Mental Residual Functional Capacity Assessment (Exhibit 1, pp. 529-547) dated [redacted], were presented. The documents were signed by a licensed psychologist as part of Petitioner's SSA claim of disability. Moderate limitations to Petitioner's understanding and memory, interaction, concentration and persistence, and adaptation were noted. Mild restrictions to understanding, interaction, and independence were separately noted. Moderate limitations to understanding and remembering detailed information, carrying out detailed instructions, maintaining attention, and interacting appropriately with the public were noted. The only apparent basis for the assessment were a consultative examination report dated [redacted].

A psychological examination report (Exhibit 1, pp. 487-491) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist. Mental health symptoms reported by Petitioner included difficulty with people, anger spells, and anxiety causing shaky hands. Noted assessments of Petitioner made by the consultative examiner include the following: orientation x 3, issues with self-esteem, fair insight, coherent speech, linear and sequential thought process, possible short-term impairment due to depression, and some paranoia. Diagnoses included moderate bipolar disorder, PTSD, and panic disorder. A mild limitation to remembering work procedures was assessed. Petitioner was deemed capable of following very short and simple instructions. Moderate-to-severe limitations to maintaining acceptable work attendance, maintaining an ordinary routine without supervision, maintaining concentration for extended periods, adapting to workplace changes were noted. Severe limitations to working with others and accepting criticism from supervisors were noted.

Generally, consultative examinations as part of SSA-benefit claims do not indicate severe restrictions. It was somewhat alarming that a consultative examiner assessed Petitioner as having multiple marked or borderline marked restrictions in work abilities.

Borderline marked restrictions to maintaining work attendance and an ordinary routine are fairly indicative of meeting listing requirements. When factoring marked restrictions to working with others and accepting criticism, it appears doubtful that Petitioner is realistically capable of maintaining employment due to marked concentration and social interaction restrictions.

Consideration was given to whether Petitioner's claims of psychological impairment were either exaggerated or generally untreated. A letter from a social worker indicated a lengthy history of treatment, though it did not state whether Petitioner regularly attended treatment. Presented medical records specifically indicated Petitioner, at one point, was not compliant with psychological treatment attendance. It is also troubling that Petitioner's alleged history of suicide attempts and hand trembling were either undocumented or marginally referenced in treatment records.

It is notable that Petitioner appears to have a history of multiple jobs lasting for short periods. Petitioner's employment history is consistent with marked concentration and

social interaction restrictions functionally rendering Petitioner incapable of maintaining employment.

It is found presented evidence established that Petitioner meets Listing 12.06. Thus, Petitioner is a disabled individual and it is found that MDHHS improperly denied Petitioner's application for 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]
(via email)

Petitioner

[redacted]