[redacted]

Date Mailed: August 23, 2017
MAHS Docket No.: [redacted] 17-008442
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 [redacted] from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], hearing facilitator. [redacted] participated as an observer.

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 5, pp. 2-8)

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 43-year-old female.

8. Petitioner's highest education year completed was the 12th grade (via general equivalency degree).

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

10. Petitioner has restrictions which allow the performance of sedentary 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 an SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS did not present a Notice of Case Action. It was not disputed that the only dispute concerned an MDHHS 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 (April 2017), p. 5. 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 (April 2017), p. 1. A person is disabled for SDA purposes if he or she meets any of the following criteria:

- Receives other specified disability-related benefits or services….
- Resides in a qualified Special Living Arrangement (SLA) facility.
- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS)...

Id., pp. 1-2.

When the person does not meet one of the [above] criteria, [MDHHS is to] follow the instructions in BAM 815, Medical Determination and Disability Determination Service (DDS), Steps for Medical Determination Applications. *Id*., p. 4. The DDS will gather and

review the medical evidence and either certify or deny the disability claim based on the medical evidence. *Id*. The review of medical evidence is primarily outlined by federal law.

[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 factors 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 us 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 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 2017 monthly income limit considered SGA for non-blind individuals is [redacted]

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.

At the second step, we consider the medical severity of your impairment(s). 20 C.F.R. §416.920 (a)(4)(ii). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination

of impairments that is severe and meets the duration requirement, we will find that you are not disabled. *Id*.

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, SSR 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).

If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. 20 C.F.R. § 416.920 (5)(c). We will not consider your age, education, and work experience. *Id*. The second step analysis will begin with a summary of presented medical documentation and Petitioner's testimony.

Emergency room documents (Exhibit 3, pp. 128-134) dated [redacted] were presented. Petitioner complained of facial numbness. A CT brain report was unremarkable.

Emergency room documents (Exhibit 3, pp. 125-127) dated [redacted], were presented. Complaints of cough and body ache were noted.

Emergency room documents (Exhibit 3, pp. 33-35) dated [redacted], were presented. Petitioner complained of headaches, neck pain, lumbar pain, and abdominal pain when coughing. Abdominal pain was suspected to be muscle-related. A referral to an orthopedist was provided.

Emergency room documents (Exhibit 3, pp. 49-54) dated [redacted], were presented. Petitioner complained of stomach pain; treatment was not apparent. Gynecological treatment was noted.

Emergency room documents (Exhibit 3, pp. 16-25, 59-66) dated [redacted], were presented. Petitioner complained of asthma and chest pain. An EKG was normal. Possible left atrial enlargement was noted following a "borderline" ECG. A chest x-ray was negative.
Emergency room documents (Exhibit 3, pp. 2-15, 67-80) dated [redacted], were presented. Petitioner complained of left-knee swelling, ongoing for 4 days. Radiology

was negative for clotting and dislocation. Medrol, Dosepak, and naproxen were prescribed.

Emergency room documents (Exhibit 1, pp. 182-198; Exhibit 3, pp. 81-97) dated [redacted], were presented. Petitioner complained of recurrent dizzy spells, nausea, and vomiting. Chest radiology was negative. Lab results were normal. Outpatient follow-up was planned.

Hospital physician encounter notes (Exhibit 3, pp. 37-41) dated [redacted], were presented. Petitioner complained of hip pain. Radiography and physical therapy were planned.

A hip radiology report (Exhibit 3, p. 45) dated [redacted], was presented. Moderate left-hip degenerative changes were noted. Mild/minimal right-hip degenerative changes were noted.

Emergency room documents (Exhibit 1, pp. 162-181; Exhibit 3, pp. 99-117) dated [redacted], were presented. Petitioner complained of left knee pain and swelling, ongoing for 5-6 days. Physical exam assessments included knee tenderness and full range of motion. Anti-inflammatories were provided. Radiology indicated mild degenerative changes. Discharge instructions for knee effusion were indicated.

Physician office visit notes (Exhibit 2, pp. 152-153, Exhibit 3, pp. 42-44) dated [redacted] were presented. Petitioner complained of hip and left knee pain (with swelling). A limp was noted. Some improvement in hip pain following an injection was reported. HTN was noted to be controlled. It was noted that Petitioner sought long-term disability but the physician refused to complete the documents. It was noted Petitioner missed an appointment with a specialist and failed to attend physical therapy.

Emergency room documents (Exhibit 2, pp. 153-159) dated [redacted], were presented. Petitioner reported right-sided back pain following a recent fall. Dyspnea was reported. Mild SI joint tenderness was noted. Chest radiology was negative. Pelvic radiology was negative. A back sprain diagnosis was noted.

Physician office visit notes (Exhibit 2, pp. 150-151) dated [redacted], were presented. Petitioner complained of bilateral hip pain. A primary diagnosis of left-hip osteoarthritis was noted; trochanteric bursitis was also noted.

A physician letter (Exhibit 2, p. 149) dated [redacted], was presented. It was noted Petitioner was able to return to work but restricted from lifting more than 25 pounds and standing for longer than 2-hour periods.

Various gynecological treatment documents (Exhibit 1, pp. 87-123, 141-155) from [redacted] were presented. Complaints of irregular menstrual bleeding was noted. Petitioner underwent a hysterectomy in late [redacted]. Post-

op documents indicated a complaint of loose stools and an emergency room visit related to hyper-intensive urgency.

Primary care physician office visit notes (Exhibit 1, pp. 124-130) dated [redacted] were presented. It was noted Petitioner presented to establish care with complaints of hip pain. Petitioner reported no pain when walking, but pain when lifting patients. A plan of continued PT was noted. Celexa was prescribed for reported anxiety.

Orthopedist office visit notes (Exhibit 1, pp. 131-133, 182-183) dated [redacted], were presented. Petitioner complained of left hip pain. PT and hip injections reportedly did not reduce pain. Physical exam assessments included a normal gait, 5/5 muscle strength, positive FABER testing, and reduced internal hip motion. An MRI hip report was performed. Assessments included moderate left-hip osteoarthritis with degenerative changes of the acetabulum.

Primary care physician office visit notes (Exhibit 1, pp. 134-140) dated [redacted] were presented. Diagnoses included restless leg syndrome and mild asthma. Various medications were continued.

Hospital documents (Exhibit 1, pp. 75-79) from an admission dated [redacted], were presented. Chest radiology was negative. A head CT was negative. Petitioner's discharge diagnosis was D-dimer elevated. A discharge date of [redacted] was noted.

Primary care physician office visit notes (Exhibit 1, pp. 156-162) dated [redacted], were presented. Treatment for s/p hysterectomy and restless leg syndrome were noted. Medication was prescribed for insomnia.

Orthopedist office visit notes (Exhibit 1, pp. 163-165m) dated [redacted], were presented. Petitioner reported ongoing hip pain and worsening lumbar pain; a fall down stairs from [redacted] was indicated (see Exhibit 1, p. 176). A normal gait was noted. MRI findings were noted to indicate mild arthritic changes. A lumbar MRI indicated "fairly well-maintained" disc space.

Spine specialist physician office visit notes (Exhibit 1, pp. 166-172) dated [redacted], were presented. Assessments included chronic right-sided lumbar pain with right-sided sciatica. Prednisone and amitriptyline were prescribed. Petitioner was referred to PT for right leg weakness.

Lumbar spine radiology (Exhibit 1, pp. 173-174) dated [redacted], was presented. Mild multi-level degenerative changes were noted.

Spine specialist physician office visit notes (Exhibit 1, pp. 176-181, 185-186) dated [redacted], were presented. Petitioner reported 15-20% improvement with PT, but ongoing constant and radiating back pain. Flare-ups were noted to be controlled with Flexeril. Difficulty carrying 25 pounds of weight was noted. A previously performed EMG

indicated nerve compression without active nerve damage. A lumbar x-ray was noted to show loss of L5-S1 disc height and anterior spondylolisthesis (grade 1). An impression of no stenosis was noted following a lumbar MRI; moderate facet arthropathy was noted at L4-L5 and L5-S1.

An internal medicine examination report (Exhibit 1, pp. 27-66) dated [redacted], was presented. The report was noted as completed by a consultative physician. Petitioner reported complaints of lumbar pain, bilateral hip pain (4/10), asthma, and shoulder pain. Notable physical examination findings included the following: a "not unsteady" normal gait, full shoulder joint motion, still and painful shoulders with movement, normal straight-leg-raising testing, reduced hip joint motion, and difficulty walking on heels. Mild impairment (at least) to lifting, crawling, walking, pushing, pulling, and bending was noted. It was noted that Petitioner was able to perform all 23 listed work-related activities which included sitting, standing, lifting, carrying, stooping, bending, and reaching, except for squatting. The examiner stated that clinical evidence did not support a need for a cane.

Petitioner testified she has tried physical therapy twice for her back and once for her hip. Petitioner testified that therapy helped "a little" for her hip, but it worsened her back pain. Petitioner testified hip injections only helped to reduce pain for 2 weeks. Petitioner testified she tries recommended home exercises when not in therapy. Petitioner testified she was told that she is too young to have hip surgery. Petitioner testified she relied on Tramadol and muscle relaxers to reduce pain. Petitioner testified Ibuprofen used to reduce pain, but is no longer effective.

Petitioner testified she is affected by asthma. Petitioner testified she quit smoking 9 months before the hearing.

Petitioner testified she has a slipped disc in her left shoulder. Petitioner testimony implied her shoulder has limited range of motion as a result.

Presented medical records generally verified a medical treatment history consistent with exertional restrictions due to hip dysfunction, asthma, and lumbar dysfunction. 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.

At the third step, we also consider the medical severity of your impairment(s). 20 C.F.R. § 416.920 (4)(iii). If you have an impairment(s) that meets or equal one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. *Id*. If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience. *Id*. 20 C.F.R. § 416.920 (d).

A listing for joint dysfunction (Listing 1.02) was considered based on hip dysfunction. 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 that Petitioner is unable to ambulate effectively or that nerve root compression causes sensory or reflex loss.

A listing for asthma (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence or exacerbations requiring three hospitalizations within a 12 month period which are also at least 30 days apart.

It is found Petitioner does not meets any SSA listings. Accordingly, the disability analysis may proceed.

If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record…. 20 C.F.R. § 416.920 (e). We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work… and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work… *Id*.

Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. 20 C.F.R. § 416.945 (a)(1). Your residual functional capacity is the most you can still do despite your limitations. *Id*. We will assess your residual functional capacity based on all the relevant evidence in your case record. *Id*. We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not "severe,"… when we assess your residual functional capacity. 20 C.F.R. § 416.945 (a)(2). We will assess your residual functional capacity based on all of the relevant medical and other evidence. 20 C.F.R. § 416.945(a)(3). We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. 20 C.F.R. § 416.945(a)(5).

At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. 20 C.F.R. § 416.920(a)(4)(iv). If you can still do your past relevant work, we will find that you are not disabled. *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 C.F.R. § 416.960(b)(1). We will not consider your vocational factors of age, education, and work experience or whether your past relevant work exists in significant numbers in the national economy. 20 C.F.R. § 416.960(b)(3).

Petitioner's submitted her work history documentation as part of her claim of disability (see Exhibit 2, p. 8). Petitioner's history included consistent employment form 2000-2016 in the field of patient care. Petitioner testified all of her past jobs were similar in that they required degrees of assisting clients with transferring, bathing, cleaning, and cooking.

Petitioner's testimony implied that she is no longer able to perform the lifting required of her past employment. Petitioner's testimony was consistent with presented records. It is found that Petitioner cannot perform past employment. Accordingly, the analysis may proceed to the final step.

If we find that your residual functional capacity does not enable you to do any of your past relevant work or if we use the procedures in § 416.920(h), we will use the same residual functional capacity assessment when we decide if you can adjust to any other work. We will look at your ability to adjust to other work by considering your residual functional capacity and the vocational factors of age, education, and work experience, as appropriate in your case. (*See* § 416.920(h) for an exception to this rule.) Any other work (jobs) that you can adjust to must exist in significant numbers in the national economy (either in the region where you live or in several regions in the country).

At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. 20 C.F.R. § 416.920(a)(4)(v). If you can make an adjustment to other work, we will find that you are not disabled. *Id*. If you cannot make an adjustment to other work, we will find that you are disabled. *Id*.

Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. 20 C.F.R. § 416.969a(a). These limitations may be exertional, nonexertional, or a combination of both. *Id*.

When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. 20 C.F.R. § 416.969a(b). When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2, we will directly apply that rule to decide whether you are disabled. *Id*.

When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. 20 C.F.R. § 416.969a(c)(1). Some examples of nonexertional limitations or restrictions include the following… nervousness, anxiousness, depression, attention or concentration deficits, difficulty remembering instructions, vision loss, hearing loss,

difficulty with environment (e.g. fumes), hand manipulation, bending, crouching, kneeling, or other body maneuvers (see *Id*.).
If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. 20 C.F.R. § 416.969a(c)(2)

Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. *Id*. To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* 20 C.F.R. § 416.967.

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. 20 C.F.R. § 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. *Id*.

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. 20 C.F.R. § 416.967(b). Even though the 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, you must have the ability to do substantially all of these activities. *Id*. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional 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 C.F.R. § 416.967(c). If someone can do medium work, we determine that he or she can also do sedentary and light 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 C.F.R. § 416.967(d). If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work. *Id*.

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 C.F.R. § 416.967(e). If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work. *Id*.

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform sedentary employment. For sedentary employment, periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday. Social Security Rule 83-10.

Petitioner testified she is limited to walking a ½ block without pain, though she can push herself to walk over a mile. Petitioner testified she is limited to standing for 5 minutes due to hip and lumbar pain. Petitioner testified she can only sit for 15 minutes without pain, but she could sit for up to an hour. Petitioner testimony estimated she could lift 15-20 pounds. Petitioner testified she can climb stairs, but with difficulty breathing.

Petitioner testified she can bathe and dress without notable difficulty. Petitioner testified she has difficulty with braiding her hair due to lumbar pain and arthritis. Petitioner testified she can make her bed and cook in small doses though sweeping is painful. Petitioner testified she us unable to bend over to do laundry or carry laundry baskets. Petitioner testified she is unable to shop since her leg went-out approximately 2-3 months before the hearing. Petitioner testified she can drive, though she does not when affected by pain medication.

Petitioner testified her knees are sometimes so swollen that she is unable to get out of bed; Petitioner estimated this occurs approximately 3 times per month. Petitioner also testified recurrent asthma attacks would make any employment challenging.

Petitioner's testimony concerning hip pain, back pain, and asthma were debatably indicative of an inability to perform even sedentary employment. Petitioner's testimony will be examined in light of presented medical evidence.

Petitioner presented no Spirometry testing. Petitioner presented no evidence of treatment for asthma attacks. Presented evidence was not persuasive in establishing respiratory restrictions to performing sedentary employment.

Treatment for knee swelling was not presented. Without treatment records, it is found Petitioner is not precluded from performing sedentary employment due to swollen knees.

A Physical Residual Functional Capacity Assessment (Exhibit 1, pp. 18-25) 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, and unlimited pushing/pulling. Petitioner was restricted to only occasional kneeling, crawling, crouching, and climbing, in part, due to shoulder and hip dysfunction. Medical records factored in the assessment included a lumbar MRI report, and consultative medical examination report.

The presented assessment from SSA was consistent with Petitioner's ability to perform sedentary employment. The assessment was consistent with presented records and not contradicted by any assessment. It is found that Petitioner is capable of performing sedentary employment. For purposes of this decision, it will be assumed that Petitioner is not capable of performing light employment.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 18-44), education (high school), employment history (unskilled), Medical-Vocational Rule 201.27 is found to apply. This rule dictates a finding that Petitioner is not disabled. Accordingly, it is found that MDHHS properly 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 properly denied Petitioner's SDA benefit application dated [redacted], based on a determination that Petitioner is not disabled. The actions taken by MDHHS are **AFFIRMED**.

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]