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: April 7, 2017
MAHS Docket No.: 17-001842
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 [redacted] Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by [redacted], specialist.

ISSUE

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

FINDINGS OF FACT

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

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

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

3. On [redacted], the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 9-15).

4. On [redacted], MDHHS denied Petitioner's application for SDA benefits and mailed a Notice of Case Action informing Petitioner of the denial.

5. On [redacted], Petitioner requested a hearing disputing the denial of SDA benefits (see Exhibit 1, pp. 2-3).

6. As of the date of the administrative hearing, Petitioner was a [redacted]-year-old female.

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

8. Petitioner's highest education year completed was the [redacted] grade.

9. Petitioner has a history of unskilled employment, including sedentary employment for a call center.

10. Petitioner has no exertional or non-exertional restrictions inhibiting the performance of former 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 [redacted] days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 531-532) dated [redacted] verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

SDA provides financial assistance to disabled adults who are not eligible for Family Independence Program (FIP) benefits. BEM 100 (July 2015), p. 4. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs. *Id*. To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older. BEM 261 (January 2012), p. 1. A person is disabled for SDA purposes if he/she:

- receives other specified disability-related benefits or services, see Other Benefits or Services below, or
- resides in a qualified Special Living Arrangement facility, or
- is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability; or
- is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Id.

Generally, state agencies such as MDHHS must use the same definition of SSI disability as found in the federal regulations. 42 CFR 435.540(a). Disability is federally defined as the inability to do any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months [90 days for SDA eligibility]. 20 CFR 416.905.

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

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

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

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

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

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

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

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

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

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

Hospital records (Exhibit 1, pp. 445-455, 491-492) dated [redacted], were presented. It was noted Petitioner presented with a complaint of general weakness, ongoing for [redacted] days. A virus was diagnosed.

Hospital records (Exhibit 1, pp. 33, 456-474, 493) dated [redacted], were presented. Petitioner reported general weakness and ongoing dizziness episodes, A CT of Petitioner's head was negative (see Exhibit 1, pp. 334-335). A chest x-ray was negative (see Exhibit 1, pp. 334-335). Diagnoses of asthenia, dizziness, and abnormal liver enzymes were noted.

Medical center encounter notes (Exhibit 1, pp. 358-437) dated [redacted], were presented. It was noted Petitioner fell over while doing morning stretches after arriving at work. It was noted a coworker of Petitioner's reported that Petitioner smelled of

alcohol. It was noted Petitioner exhibited no syncope episodes, but did smell of alcohol while in the emergency department. Clinical impressions of syncope and alcohol intoxication were noted.

Physician encounter documents (Exhibit 1, pp. 211-220) dated [redacted], were presented. It was noted that Petitioner complained of dizziness, ongoing intermittently since [redacted]. Dizziness episodes were noted to last [redacted] days and to occur every few days. Tilting back of the head was noted as an exacerbating factor; taking meclizine was noted to help. Referrals to neurology and cardiology were noted.

Cardiologist office visit notes (Exhibit 1, pp. 221-229) dated [redacted] were presented. It was noted that Petitioner complained of chronic syncope episodes. A plan of an EEG and carotid Doppler were noted.

An echocardiogram report (Exhibit 1, pp. 343-345) dated [redacted], was presented. Petitioner's ejection fraction was 62%.

Neurologist office visit notes (Exhibit 1, pp. 34, 229-236, 483-485) dated [redacted], were presented. It was noted that Petitioner presented for follow-up of syncope episodes. Complaints of amnesia and frequent falling were also noted. An EEG and MRI were scheduled.

A brain MRI report (Exhibit 1, pp. 336-337) dated [redacted], was presented. A normal report was noted.

An EEG report (Exhibit 1, pp. 341-342) dated [redacted], was presented. A normal report was noted.

Physician office visit notes (Exhibit 1, pp. 238-249) dated [redacted], were presented. It was noted that Petitioner presented for ongoing syncope episodes. It was noted Petitioner would usually fall during an episode, but lose consciousness. Memory loss, confusion, and shaky hands was reported as typically following an episode. Episode effects reportedly lasted for hours-to-days. It was noted Petitioner reported an ongoing episode from that morning; it was also noted Petitioner held onto her friend (who appeared with Petitioner for the appointment). An EtOH was ordered because Petitioner smelled of alcohol at an earlier medical appointment. It was noted a CT of Petitioner's head from [redacted] was negative. A complaint of lumbar pain was also noted, but not apparently treated.

Physician office visit notes (Exhibit 1, pp. 249-258) dated [redacted], were presented. It was noted that Petitioner presented for follow-up for syncope episodes and depression. Reported symptoms included decreased concentration, depressed mood, irritability, poor sleep, and anxiety. Normal ranges of motion and cervical and lumbar spine tenderness to palpation was noted in a physical examination. Zoloft was

prescribed for depression. Acetaminophen-codeine was prescribed for back pain. Petitioner was referred to an ENT physician for dizziness.

Audiologist office visit notes (Exhibit 1, pp. 258-269) dated [redacted], were presented. It was noted that ear testing was limited due to patient alertness. Testing was noted to be consistent with normal hearing.

Physician office visit notes (Exhibit 1, pp. 270-273) dated [redacted], were presented. It was noted that Petitioner reported ongoing syncope episodes (twice per week), since [redacted]. Videonystagmography testing was noted to be abnormal. Possible explanations included abnormal neurology, drunkenness, and/or drowsiness.

Physician office visit notes (Exhibit 1, pp. 273-284) dated [redacted], were presented. It was noted that Petitioner reported no syncope episodes in previous [redacted] weeks. Ongoing non-radiating back pain was reported. Normal range of motion was noted. It was noted Petitioner was moving to a homeless shelter. Naproxen was prescribed for back pain. It was noted Petitioner was "ready to quit alcohol: and that she "has been titrating down."

Physician office visit notes (Exhibit 1, pp. 284-293) dated [redacted] were presented. It was noted that Petitioner reported right hand pain and swelling, ongoing for [redacted] days. No incident was reported as causing the injury. A sprain was diagnosed. An x-ray was negative (see Exhibit 1, p. 294).

Physician office visit notes (Exhibit 1, pp. 293-303) dated [redacted], were presented. It was noted that Petitioner reported ongoing right hand pain (7/10). Decreased range of motion and tenderness were noted. A referral to orthopedics was noted. A splint was issued. An x-ray was negative (see Exhibit 1, p. 305).

Physician office visit notes (Exhibit 1, pp. 304-312) dated [redacted], were presented. It was noted that Petitioner reported ongoing right hand pain. Reduced right hand grip strength was noted. A CT of Petitioner's hand was planned.

Physician office visit notes (Exhibit 1, pp. 312-321, 475-477) dated [redacted] were presented. It was noted a CT (see Exhibit 1, p. 340) demonstrated a metacarpal fracture. "Excellent" range of finger motion was noted. A follow-up in 4 was planned. Physical therapy for gentle range of motion was also planned.

Physician office visit notes (Exhibit 1, pp. 478-480) dated [redacted], were presented. It was noted that Petitioner reported hand pain and feelings of being overwhelmed and. It was noted Petitioner was tearful. Treatment details were not apparent.

Physician office visit notes (Exhibit 1, pp. 322-334) dated [redacted], were presented. It was noted Petitioner complained of urinary frequency. Urology testing was planned.

Hospital document (Exhibit 1, p. 511-512) dated [redacted], was presented. Spirometry testing for COPD was requested. Hepatitis testing and a chest CT were also ordered.

Hospital documents (Exhibit 1, pp. 508-510) dated [redacted], were presented. Diagnoses of alcohol abuse and acute respiratory failure were noted. Various medications were continued.

Hospital documents (Exhibit 1, pp. 514-521) dated [redacted], were presented. It was noted Petitioner presented with altered mental status. A brain CT report (Exhibit 1, p. 35, 524) noted no acute intracranial process. Chest x-rays were negative (see Exhibit 1, p. 525). Alcohol abuse was noted.

Chest radiology (Exhibit 1, p. 36) dated [redacted], was presented. An impression of no acute process was noted.

A cervical spine MRI report (Exhibit 1, pp. 37-38) dated [redacted], was presented. Degenerative disc disease at C5-C6 was noted. A subacute compression deformity consistent with a fracture was noted at T3

Various documents from an alcohol rehabilitation center (Exhibit 1, pp. 156-203) from [redacted] and [redacted] were presented. It was noted Petitioner's first contact occurred on [redacted]. Petitioner appeared to return on [redacted]. Petitioner was discharged on [redacted] after graduating treatment. Various post-treatment goals were noted.

A physician letter (Exhibit A, p. 1) dated [redacted], was presented. A walker with a seat was ordered for Petitioner.

Petitioner testified she has multiple physical problems. Many of the alleged problems were not documented.

Petitioner testified that her hips are out-of-joint. No treatment for hip alignment was apparent.

Petitioner testified she has a metal plate that sticks out of her right foot. Petitioner testified the plate was inserted following a previous bunion surgery. Petitioner testified she needs surgery which would require [redacted] weeks without walking. No evidence of treatment was apparent.

Petitioner testified she has right knee pain. Petitioner testified her right knee recurrently swells. Petitioner testified she had [redacted] previous surgeries on her right knee. No evidence of treatment was apparent.

Petitioner testified she has vision difficulties. Petitioner testified her vision is like having spider webs in her eyes. Petitioner testified cataracts were twice removed from her eyes. No evidence of treatment was apparent.

Petitioner alleged restrictions, in part, due to COPD. Petitioner testimony admitted she is an ongoing smoker. More notably, no diagnosis was verified. An order for respiratory testing was documented, though results were not presented.

Petitioner testified she has nerve pain in her hands. Petitioner testified she does not see a neurologist. No evidence of hand nerve treatment was apparent.

Though much of Petitioner's testimony was unverified, some of Petitioner's allegations were supported. Degrees of physical and psychology restrictions were verified.

Presented records verified a history of vertigo episodes. Petitioner testified her vertigo is caused by the way her eyes connect to her brain. Petitioner testified she is taking medication to combat the episodes.

Petitioner testified she had a recent fall from a vertigo episode which caused her to break bones in her right hand. Documentation of the fall was not provided (unless Petitioner was referencing records from [redacted]).

Complaints of back pain and a mid-back fracture were documented. Presumably, the fracture healed as follow-up to radiology verifying the fracture was not presented. Petitioner testified she has back arthritis for which she attends physical therapy; Petitioner testified the PT does not help. Petitioner testified she takes prescribed Ibuprofen for pain.

A metacarpal fracture was verified. There was little evidence that the problems were ongoing. Based on Petitioner's testimony, some degree of lifting/carrying restriction will be inferred.

Complaints of depression and/or anxiety were verified. Petitioner testified she will soon start seeing a psychiatrist. Petitioner testified depression makes her tired. Some degree of concentration restriction can be inferred based on Petitioner's treatment history.

Presented medical records generally verified a medical treatment history consistent with degrees of concentration, ambulation, and lifting/carrying restrictions. The treatment history was established to have lasted at least 90 days and at least since Petitioner's date of SDA application. Accordingly, it is found that Petitioner established having a severe impairment and the disability analysis may proceed to Step 3.

The third step of the sequential analysis requires determining whether the Petitioner's impairment, or combination of impairments, is listed in 20 CFR Part 404, Subpart P, appendix 1. 20 CFR 416.920 (a)(4)(iii). If a petitioner's impairments are listed and deemed to meet the durational requirement, then the petitioner is deemed disabled. If the impairment is unlisted or impairments do not meet listing level requirements, then the analysis proceeds to the next step.

A listing for joint dysfunction (Listing 1.02) was considered based on Petitioner's complaints of knee pain. The listing was rejected due to a failure to establish that Petitioner is unable to ambulate effectively.

A listing for spinal disorders (Listing 1.04) was considered based on back pain complaints. This listing was rejected due to a failure to establish a spinal disorder resulting in a compromised nerve root.

A listing for visual acuity (Listing 2.02) was considered based on complaints of cataracts. This listing was rejected due to a failure to establish a corrected eyesight of worse than 20/200 in Petitioner's best eye.

A listing for chronic pulmonary insufficiency (Listing 3.02) was considered based on Petitioner's complaints of dyspnea. The listing was rejected due to a lack of respiratory testing evidence.

A listing for affective disorder (Listing 12.04) was considered based on diagnosis of depression. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner required a highly supportive living arrangement, suffered repeated episodes of decompensation, or that the residual disease process resulted in a marginal adjustment so that even a slight increase in mental demands would cause decompensation.

A listing for anxiety-related disorders (Listing 12.06) was considered based on Petitioner's treatment for anxiety. This listing was rejected due to a failure to establish marked restrictions in social functioning, completion of daily activities or concentration. It was also not established that Petitioner had a complete inability to function outside of the home.

A listing for inflammatory arthritis (Listing 14.09) was considered based on Petitioner's complaints of arthritis. The presented medical records were insufficient to establish that Petitioner has an inability to ambulate effectively, perform fine and gross movements, or suffers inflammation or deformities with a diagnosis of ankylosing spondylitis or other spondyloarthropathies, or suffers repeated manifestations of inflammatory arthritis.

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

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

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

Petitioner testified she worked as a packager. Petitioner testified her job was to stand in a line and tape boxes.

Petitioner testified she worked from [redacted] as a gate agent. It is assumed that Petitioner's job was to stand at an airplane boarding gate and assist customers.

Petitioner testified she also worked at multiple call centers. One of Petitioner's jobs was to make travel arrangements for customers of a credit card company. Petitioner testimony implied the jobs were sedentary in nature.

Sedentary work involves lifting of no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. 20 CFR 416.967(a). Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. *Id.* Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Petitioner testified she is required to use a walker because she is a falling danger. Petitioner testified she can only walk a few steps without her walker. Petitioner testified she may be able to walk [redacted] blocks with a walker. Petitioner testified she could stand for 15 minutes with the use of her walker. Petitioner testified she could only sit for 3-4 hours out of an 8 hour workday because of a need to lie down due to back pain. Petitioner testified she is limited to lifting/carrying 10 pounds, presumably due to back pain. Petitioner testified her hands are numb, possibly due to lumbar problems.

Petitioner testified she can bathe herself, though she must be careful about tilting her head back to not cause dizziness. Petitioner testified she can dress herself, if she sits.

Petitioner testified she is unable to vacuum or get on her floors to clean them. Petitioner testified she can shop and drive for short periods.

Petitioner's testimony was indicative of sitting, ambulation, and gripping restrictions which would likely preclude the performance of call center employment. Petitioner's testimony was consistent with a letter from her physician.

A physician letter (Exhibit A, p. 1) dated [redacted], was presented. The letter stated Petitioner had sever lumbar arthritis, chronic vertigo requiring use of a walker, depression, and anxiety. The physician stated Petitioner's various problems severely affected her functioning. The physician opined Petitioner should be eligible for disability.

Presented documents failed to verify an explanation for the Petitioner's vertigo episodes. Brain radiology was negative. ENT findings were negative. Neurology was negative. VNG testing was somewhat supportive of a physical cause of vertigo, though so was alcohol abuse.

It is notable that Petitioner completed alcohol rehabilitation in [redacted]. No treatment for vertigo was apparent after Petitioner's rehab stint. Petitioner's physician prescribed a walker for Petitioner after [redacted], though medical documentation was not presented to justify the order.

If Petitioner has ongoing vertigo complaints, it is presumed that her episodes are less frequent, after [redacted] assuming Petitioner abstains from alcohol abuse. Even if is presumed that Petitioner's recurrent vertigo and falling problems are caused by something other than alcohol abuse, the recurrence of episodes since Petitioner applied for SDA episodes was not verified. Zero treatment records for vertigo after Petitioner's rehab stint were presented.

Petitioner's physician diagnosed Petitioner with "severe" arthritis. The basis for the degree of arthritis is not apparent. A diagnosis of arthritis was not apparent in any treatment records. Some degree of restriction could be inferred, but not enough to restrict Petitioner from performing employment as a call center representative.

Petitioner's physician also noted Petitioner had debilitating psychological obstacles. Complaints of depression and anxiety were noted. Ongoing psychiatric treatment was absent. The most insightful evidence of Petitioner's psychological function came from a consultative examiner.

A mental status examination report (Exhibit 1, pp. 149-152) dated [redacted], was presented. The report was noted as completed by a consultative licensed psychologist and a limited licensed psychologist. Complaints of anxiety, and various physical problems were reported. It was noted Petitioner was in alcohol rehabilitation. Quality of ADLs were reported to be "good." Assessments including no difficulties with comprehension, carrying-out simple directions, performing repetitive tasks, or

comprehending complex tasks. Diagnoses included depression (secondary to medical condition). PTSD (per Petitioner), alcohol dependence in remission, and panic disorder (unobserved). A fair prognosis was noted. The assessments were consistent with an ability to perform employment as a call center representative.

SSR 96-2p states that if a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it must be given controlling weight (i.e. it must be adopted). Treating source opinions cannot be discounted unless the Administrative Law Judge provides good reasons for discounting the opinion. *Rogers v. Commissioner,* 486 F. 3d 234 (6th Cir. 2007)*; Bowen v Commissioner.*

Generally, a consultative examiner is not preferred over a treating source opinion. The present case justifies exception.

The consultative examiner provided some basis for presented medical opinions. A report was presented. Interview questions were documented. There was a degree of support for all stated assessments.

Petitioner's physician appeared to simply provide a generic medical opinion. Past treatment was apparent, though not enough to support a finding of severe mental illness.

It is found Petitioner does not have exertional or non-exertional restrictions precluding performance of past employment as a call center representative. Accordingly, Petitioner is not disabled and it is found that MDHHS properly denied Petitioner's SDA application.

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]