



RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

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Date Mailed: April 28, 2017
MAHS Docket No.: 17-002377
Agency No.: ██████████
Petitioner: ██████████

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 ██████████, from Detroit, Michigan. Petitioner appeared and was unrepresented. The Michigan Department of Health and Human Services (MDHHS) was represented by ██████████, medical contact worker.

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 ██████████, Petitioner applied for SDA benefits.
2. Petitioner's only basis for SDA benefits was as a disabled individual.
3. On ██████████, the Disability Determination Service determined that Petitioner was not a disabled individual (see Exhibit 1, pp. 10-18).
4. On ██████████, 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, p. 182).
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 47-year-old female.
8. Petitioner's highest education year completed was the 10th grade.
9. Petitioner has a history of unskilled employment, with no known transferrable job skills.
10. Petitioner has lumbar dysfunction which allows a full range 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).

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.*

Petitioner requested a hearing to dispute the denial of a SDA application. Petitioner claimed an inability to work for 90 days due to mental and/or physical disabilities. MDHHS presented a Notice of Case Action (Exhibit 1, pp. 178-181) dated January 24, 2017, verifying Petitioner's application was denied based on a determination that Petitioner was not disabled.

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 [REDACTED].

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 F.2d 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.

Primary-care physician (PCP) office visit notes (Exhibit 1, pp. 135-140) dated [REDACTED], were presented. Treatment for COPD, back pain, DM, hyperlipidemia, HTN, GERD, and obesity were noted.

Hospital documents (Exhibit 1, pp. 161-177) dated [REDACTED], were presented. It was noted that Petitioner presented after she slipped and fell on a grocery store floor. Petitioner testified the fall caused her to twist her back. Medical records noted Petitioner reported feeling a popping sensation in her back. Right knee, lumbar, chest, and hip pain were reported. Chest, hip, lumbar, and knee x-rays were normal. Diagnoses included back pain, bruised knee, and acute right hip pain.

PCP office visit notes (Exhibit 1, pp. 141-143) dated [REDACTED], were presented. Back pain from a slip-and-fall was reported. Baclofen was prescribed for COPD. A lumbar spine MRI was planned.

PCP office visit notes (Exhibit 1, pp. 144-146) dated [REDACTED], were presented. Ongoing back pain (9/10) was reported. Petitioner reported chronic back pain before the

fall, however, a new symptom of radiating pain (to leg) was reported. Pain medications were noted to be unhelpful. Lyrica was prescribed.

Physical rehabilitation physician office visit notes (Exhibit 1, pp. 114-117) dated [REDACTED], were presented. It was noted Petitioner complained of lumbar pain radiating to her right leg (pain level 7-10/10). Pain was reported to be worse with activity and slightly better with rest and medication. Prescribed medications included Gabapentin, Norco, Pamelor, and Robaxin. Petitioner was taken off work and attendant care for 8 hours per day was authorized. Physical therapy (PT) was planned. A cane and back brace were prescribed.

Physical rehabilitation physician office visit notes (Exhibit 1, pp. 109-113) dated [REDACTED], were presented. Ongoing back treatment was noted. It was noted Petitioner reported slightly improved ongoing lumbar pain. It was noted Petitioner ambulated with a cane. It was noted Petitioner needed help with unspecified ADLs. A MRI was planned. Attendant care was decreased from 8 hours per day to 6 hours per day. Electrodiagnostic testing demonstrated no evidence of electrical instability (see Exhibit 1, p. 113). Medications and PT were continued.

A lumbar spine MRI report (Exhibit 1, pp. 40-41, 123-124, 152-153) dated [REDACTED] was presented. An impression of a bulging disc at L3-L4 was noted. An annular tear and facet hypertrophy at L4-L5 were noted to cause mild-to-moderate left-sided foraminal stenosis. Mild-to-moderate left-sided foraminal stenosis was also noted at L5-S1.

Physical rehabilitation physician office visit notes (Exhibit 1, pp. 105-108) dated [REDACTED] were presented. Ongoing back treatment was noted. It was noted Petitioner reported ongoing burning left lumbar radicular pain (7/10). It was noted Petitioner ambulated with a cane. Muscle strength, neurology, and reflexes were normal. Limited range of motion and tenderness to palpation of the lumbar was noted. Positive slump and straight-leg-raising tests (on the right) were noted. A plan of steroid injections, continuing medications, and continuing PT was noted. Attendant care was decreased from 6 hours per day to 5 hours per day.

PCP office visit notes (Exhibit 1, pp. 147-149) dated [REDACTED], were presented. Reportedly high blood sugars were noted. Metformin was prescribed.

Cardiovascular physician office visit notes (Exhibit 1, pp. 126-128) dated [REDACTED], were presented. It was noted that Petitioner reported heart palpitations and dyspnea upon mild exertion. It was noted Petitioner reported increased stress due to the loss of a child. Petitioner was noted to be a pack per day smoker. Zocor was prescribed. A carotid Doppler study was planned.

Carotid Doppler test results (Exhibit 1, p. 129) dated [REDACTED], was presented. A conclusion of minimal atherosclerotic disease with minimal stenosis was noted.

Physical rehabilitation physician office visit notes (Exhibit 1, pp. 101-104) dated [REDACTED], were presented. Ongoing back treatment was noted. It was noted Petitioner reported ongoing left lumbar radicular pain. It was noted Petitioner responded well to injections, though the positive effect was dwindling. It was noted Petitioner ambulated with a cane. Muscle strength, neurology, and reflexes were normal. Limited range of motion and tenderness to palpation of the lumbar was noted. Positive slump and straight-leg-raising tests (on the right) were noted. A plan of repeated steroid injections, continuing medications, and continuing PT was noted. Attendant care was decreased from 5 hours per day to 4 hours per day.

A Medical Examination Report (Exhibit 1, pp. 42-44, 154-156) dated [REDACTED], was presented. The form was completed by a physical medicine physician with an approximate 3-month history of treating Petitioner. Petitioner's physician listed diagnoses of lumbar radiculopathy and lumbar sprain. An impression was given that Petitioner's condition was stable. Lumbar restrictions in flexion, extension, and bending were noted. Muscle strength was 5/5. It was noted that Petitioner needed assistance with dressing, shopping, bathing, using restroom, cooking, and yard work. It was noted that Petitioner did not need an assistive device for ambulation.

Physical rehabilitation physician office visit notes (Exhibit 1, pp. 97-100) dated [REDACTED] were presented. Ongoing back treatment was noted. It was noted Petitioner has gained weight since her accident due to limited mobility. It was noted medications were slightly dulling Petitioner's pain. Limited flexion, extension, and bending were noted. A positive slump test on the right was noted. Lower extremity muscle testing was normal. Steroid injections, aqua therapy, and continuing medications were recommended

Various Disability Certificates (Exhibit A, pp. 2-6) signed by Petitioner's rehab physician were presented. The certificates covered the period from [REDACTED], through [REDACTED]. A Disability Certificate (Exhibit A, p. 1) covering [REDACTED] was also presented. It was consistently noted Petitioner was disabled from working and in need of attendant care and assistance with housework.

Medical evidence verified treatment for heart disease. A diagnosis of minimal arteriosclerotic disease with minimal stenosis was verified. The diagnosis was not indicative of restrictions to Petitioner's performance of basic work abilities. This conclusion is consistent with the apparent absence of follow-up treatment to Doppler testing. It is found Petitioner did not establish an impairment related to heart disease.

Petitioner testified she has unbearable lumbar pain. Petitioner testified she has undergone PT since injuring her back; Petitioner testified any relief from PT is gone after a day. Petitioner testified she tries to apply heat to her spine to reduce pain. Petitioner testified she is scheduled to undergo a laser procedure which will burn tissue (presumably, ablation) to relieve pain.

Presented documents sufficiently verified a degree of lumbar dysfunction. The problem would reasonably restrict Petitioner's carrying/lifting, ambulation, sitting, and standing. Petitioner's treatment history was consistent with restrictions that 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.

Petitioner's most prominent impairment appears to be back pain due to multiple spinal problems. Spinal disorders are covered by Listing 1.04 which reads:

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);

OR

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;

OR

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

Looking at Part C, the inability to ambulate effectively is a requirement. SSA defines this as follows:

Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

Petitioner's physician stated that Petitioner does not have a need for a walking-assistance device. It is possible that Petitioner's physician mistakenly answered the question about the need, however, such consideration is speculative. Without a need for a cane, Petitioner cannot be found to meet the SSA listing for spinal disorders. It is found that Petitioner failed to establish meeting (or equaling) an SSA listing. Accordingly, the analysis moves to the fourth step.

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

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

Petitioner testified her only full-time employment from the past 15 years was self-employment as a house cleaner. Presumably, Petitioner's employment included vacuuming, sweeping, mopping, and dusting. It is presumed the employment required long periods of standing and/or ambulation.

Petitioner testimony implied that she is unable to perform the standing, bending and/or walking required of past employment. Petitioner's testimony was credible and consistent with presented evidence. It is found that Petitioner is unable to perform past employment and the analysis may proceed to the final step.

In the fifth step in the process, the individual's RFC in conjunction with his or her age, education, and work experience, are considered to determine whether the individual can engage in any other substantial gainful work which exists in the national economy. SSR 83-10. While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978). Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix II, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983). To determine the physical demands (i.e. exertional requirements) of work in the national economy, jobs are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967.

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

Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds. 20 CFR 416.967(b) Even though weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. *Id.* To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. *Id.* An individual capable of light work is also capable of sedentary work, unless there are additionally limiting factors such as loss of fine dexterity or inability to sit for long periods of time. *Id.*

Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). An individual capable of performing medium work is also capable of light and sedentary work. *Id.*

Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). An individual capable of heavy work is also capable of medium, light, and sedentary work. *Id.*

Finally, very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying objects weighing 50 pounds or more. 20 CFR 416.967(e). An individual capable of very heavy work is able to perform work under all categories. *Id.*

Limitations or restrictions which affect the ability to meet the demands of jobs other than strength demands are considered non-exertional. 20 CFR 416.969a(a). Examples of non-exertional limitations include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (e.g. can't tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi) If the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2)

The determination of whether disability exists is based upon the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2. *Id.* In using the rules of Appendix 2, an individual's

circumstances, as indicated by the findings with respect to RFC, age, education, and work experience, is compared to the pertinent rule(s).

Given Petitioner's age, education and employment history a determination of disability is dependent on Petitioner's ability to perform 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 relies on a walker at home, and a cane when she leaves her home. Petitioner testified she cannot walk longer than a block and has not tried to walk without a walking-assistance device since her injury. Petitioner testified she is limited to standing of 5-8 minutes with a walker before she experiences shooting pain in her right leg. Petitioner testified she is restricted to sitting for 15 minutes, presumably due to lumbar pain. Petitioner testified she has no restrictions with her arms.

Petitioner testified she needs assistance with bathing and putting on her socks and shoes. Petitioner testified she is incapable of performing any housework. Petitioner testified she cannot perform the bending required of doing laundry. Petitioner testified she does not typically go shopping, but when she does, she relies on a scooter.

Petitioner's testimony concerning ambulation, standing, and ADLs was highly indicative of an inability to perform any employment. Petitioner's testimony was inconsistent with some presented evidence.

On a Medical Examination Report dated [REDACTED], Petitioner's physician stated Petitioner had various limitations. Standing, walking and sitting restrictions were not stated. Petitioner was restricted from lifting/carrying weights even less than 10 pounds. Petitioner's physician opined that Petitioner was restricted from performing repetitive actions with right legs/feet. Petitioner's physician cited a bulging disc at L3-L4 and L5-S1 hypertrophy as support for the restrictions. The stated limitations were stated as NOT expected to last 90 days.

Consideration was given to Petitioner's physician's statements of Petitioner's need for assistance. Documented needs for assistance with toileting, housework, and dressing are highly indicative of an inability to perform any employment. Though these statements were indicative of disability, most evidence was not.

Petitioner's physician also noted that Petitioner's stated limitations were not expected to last 90 days and that evidence did not support a need for a walking assistance device. These statements are indicative of gradual improvement. Gradual improvement was also consistent with gradual reductions in authorized hours for attendant care.

Presented lumbar radiology verified mild-moderate stenosis at 2 disc spaces and an annular tear. An annular tear is indicative of disc degeneration, though not particularly severe enough to cause an inability to perform any employment. Mild-to-moderate stenosis, is indicative of pain, particularly at multiple disc spaces, however, the pain is

not likely to be so unbearable to restrict Petitioner from performing sedentary employment.

Petitioner testified her walking difficulty is partly caused by nerve damage to her right leg. Petitioner's testimony was not well-supported. Muscle strength was consistently noted to be full. Neurological abnormalities were not apparent. Neurologist treatment was not documented.


Generally, Petitioner's statements of restrictions were credible. The statements were simply not sufficiently supported by medical evidence to justify a finding that Petitioner cannot perform sedentary employment. It is found Petitioner is capable of performing a full range of performing sedentary employment.

Based on Petitioner's exertional work level (sedentary), age (younger individual aged 45-49), education (limited but literate and capable of communicating in English), employment history (unskilled), Medical-Vocational Rule 201.18 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]
[REDACTED]
[REDACTED]

Petitioner

[REDACTED]
[REDACTED]
[REDACTED]