[redacted]

Date Mailed: June 29, 2018
MAHS Docket No.: 18-003127
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on May 31, 2018 from Detroit, Michigan. Petitioner appeared for the hearing with his relative [redacted] and represented himself. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payments Worker. [redacted] Assistance Payments Supervisor served as [redacted] interpreter.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

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 or around July 24, 2017 Petitioner submitted an application for cash assistance on the basis of a disability.

2. On or around March 2, 2018 the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.

3. On March 9, 2018 the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled.

4. On March 26, 2018 Petitioner submitted a timely written Request for Hearing disputing the Department's denial of his SDA application.

5. Petitioner alleged disabling impairments due to: back and neck pain; impaired mobility; high blood pressure; asthma; dizziness; difficulty using his hands; depression; and anxiety.

6. As of the hearing date, Petitioner was [redacted] years old with an [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

7. Petitioner did not receive a high school diploma or GED. His highest level of education is the [redacted] grade and requires the assistance of an [redacted] interpreter.

8. Petitioner has employment history of work as a sailor on a naval ship where he was responsible for cooking, cleaning, and deck work. He also has employment history as a busboy in a restaurant.

9. Petitioner has a pending disability claim with the Social Security Administration (SSA).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a

determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, he is not ineligible at Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence

shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. Id.; SSR 96-3p.

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below:

On February 21, 2018 Petitioner participated in a consultative Internal Medicine Examination. Petitioner reported that his primary problems are related to his neck and back, and complained of a three year history of neck pain that radiates to the hands with intermittent numbness. He reported that he received an injection to both sides of his neck last week with no improvement. Petitioner reported three year history of low back pain with radiation to the feet that has not been treated other than with medication. It was noted that Petitioner had an MRI of the cervical spine in May 2017 which showed multilevel small disc protrusions and at C5-C6, the disc protrusion came close to compressing the spinal cord. It was further noted that Petitioner had an MRI of the lumbosacral spine in July 2017 which showed minimal bulging disc at L4-L5 without spinal stenosis. Petitioner reported history of depression and anxiety for which he is receiving treatment and a 25 year history of asthma with one prior hospitalization due to exacerbation six months prior. He reported that his asthma is triggered by exertion, smells, and dust. It was noted that Petitioner ambulates with a normal gait, which was not unsteady, lurching or unpredictable. He did not require the use of a handheld assistive device and appeared stable in standing, sitting and supine positions. It was noted that he had a somewhat depressed affect and seemed sleepy. Examination of Petitioner’s neck, chest, cardiovascular, and abdomen yielded normal findings. Examination of Petitioner’s hands revealed: no tenderness, redness, warmth, swelling; no atrophy and he was able to make a fist bilaterally; there were no Heberden or Bouchard’s nodes; his grip strength was within normal limits and he was able to write with his dominant hand and pick up coins with both hands without difficulty. Petitioner’s lower extremities, cervical spine and dorsolumbar spine examination were within normal

range, as was his neurological examination. His pulmonary function test showed FVC 3.50 and FEV1 showed 2.76. The final impression of the doctor was that Petitioner has: moderate persistent asthma; chronic neck pain with radiation to hands with history of small disc protrusions; chronic low back pain with radiation to the feet with history of disc bulge at L4-L5; chronic depression and anxiety (medically treated and seeing a therapist); and hypertension with borderline control. In summary, the doctor indicated that Petitioner's upper and lower extremities had normal function, strength and range of motion. His lung examination was normal and it was noted that his ability to perform work-related activities such as bending, stooping, lifting, walking, crawling, squatting, carrying and traveling as well as pushing and pulling heavy objects was not impaired.

Petitioner's progress notes/records from [redacted] were presented for review and show that on September 13, 2017 he presented for follow-up after being admitted to the hospital with chest pain. While at the hospital, he underwent CTA which was negative for PE, 2-D echo which showed normal systolic function and a nuclear stress test which showed low risk findings. A July 2017 myocardial spect showed minimal to mild, partially reversible perfusion defect involving the left ventricular apex without evidence of a fixed perfusion. His ejection fraction was 55% at that time. Petitioner presented records from his March 2018 visit showing that he continued to receive treatment for his chest pain and heart palpitations. (Exhibit 1)

Petitioner's [redacted] treatment records from his primary care physician (PCP) were presented for review and indicate he has past history of hypertension, asthma and depression. The records indicate that he was prescribed several medications and on more than one visit, reported back and neck pain and dizziness. It was recommended that Petitioner stop smoking to help with his asthma symptoms. Records show Petitioner was diagnosed with and receiving treatment for palpitations, cervical radiculopathy, hypertension, tachycardia, low back pain and lumbar radiculopathy. Physical examination during multiple visits did not reflect any noted abnormalities. Records indicate in August 2017 he was seen for an asthma attack.

A July 28, 2017 MRI of the lumbar spine showed minimal bulging disc at L4-L5 without focal disc herniation or significant stenosis. A May 30, 2017 MRI of Petitioner's cervical spine showed mild degenerative changes, greatest at C3-C4 with borderline central canal stenosis and mild right neuroforaminal stenosis. There was also mild reversal of normal cervical lordosis noted.

November 2016 to September 2017 mental health treatment records from [redacted] were presented and reviewed. A November 2016 assessment showed that Petitioner reported symptoms of anxiety and depression for the last one year and reported taking medications prescribed by his PCP. He had no psychiatric hospitalization history and denied any history of suicidal or homicidal ideations. It was noted that Petitioner reported depressive mood, isolation, low motivation, change in social and occupational functioning, fatigue, insomnia, feelings of worthlessness, excessive guilt, and diminished ability to think or concentrate. He was diagnosed with major depressive disorder, recurrent moderate. A December 2016 psychiatric

evaluation showed: his awareness was dull; his judgment fair; he had a slowed or delayed response; his concentration was distractible; and he had depressed and anxious affect. His GAF score was 55. Progress Notes from February 2017 indicate that Petitioner reported hearing voices, sounds and music. He reported not wanting to be around people and continued to isolate himself. He was not bathing regularly and struggling with decision making. It was noted that Petitioner appeared much older than his actual age and was observed to have a normal gait. His thought content did not contain suicidal or homicidal ideations and was additionally diagnosed with major depressive disorder, single episode severe with psychotic features. March 2017 Psychiatric Progress Notes indicate that Petitioner reported experiencing high anxiety but stated his mood is a little better and sleep greatly improved. Petitioner was diagnosed with panic disorder with agoraphobia. In an April 5, 2017 therapy session Petitioner reported that his doctor had changed his medications and they have been helping more. He reported going to physical therapy to help with neck and back pain and further reported that he has been going out more due to good weather. In May 2017 Petitioner reported to his counselor that he has been having difficulties with anger and having terrible nightmares and difficulty sleeping. In June 2017 Petitioner reported to the psychiatrist that his depression and anxiety were under control with meds. The doctor noted that Petitioner had: a normal gait; good grooming and hygiene; pleasant and cooperative attitude; good eye contact; normal psychomotor activity; good mood; affect full range and congruent to mood and his thought content contained no suicidal or homicidal ideations. His insight and judgment were intact and no perceptual disturbances were evident. September 2017 Psychiatric Progress Notes indicate that Petitioner reported doing better with his medications and seeing a therapist every two weeks. He denied any side effects from current medications but continued to have high anxiety. His stressed mood appeared to be tied to his social and financial circumstances.

October 2016 to December 2017 records from [redacted] show that Petitioner was treated in the emergency department (ED) on several occasions for alcohol intoxication, withdrawal and related issues. On October 9, 2016 Petitioner presented to the ED with alcohol intoxication which resulted in him falling, causing a facial laceration that was repaired. A CT of the head showed mild mucosal disease and a small hematoma. On October 14, 2016 Petitioner presented to the ED with alcohol intoxication and reported pain and anxiety. He was released after treatment. Petitioner was admitted to the hospital on October 18, 2016 for alcohol withdrawal and anxiety. Petitioner was diagnosed with and treated for hypokalemia, hypomagnesemia, hypertension, metabolic alkalosis, mild anemia and alcohol withdrawal. He was discharged on October 22, 2016 after his symptoms improved. It was noted that upon nephrology evaluation, his nutritional deficiency was found to be due to alcoholism rather than increased potassium on exertion in urine. Petitioner presented to the hospital on multiple occasions in 2016 for similar incidents. In July 2017 Petitioner was admitted to the hospital for two days with complaints of chest pain. His alcohol level was found to be elevated and he was diagnosed with alcohol induced gastritis. He underwent CTA which was negative for pulmonary embolism, 2-D echo which showed normal systolic function and a nuclear stress test which showed low risk

findings. A July 2017 myocardial spect showed minimal to mild, partially reversible perfusion defect involving the left ventricular apex without evidence of a fixed perfusion. His ejection fraction was 55% at that time. An EEG performed was moderately abnormal. He was treated and discharged and instructed to follow-up with a cardiologist, whose records are reflected above. In September 2017 Petitioner presented to the ED and was diagnosed with alcohol abuse and major depression. He was released after treatment and was to follow-up with his PCP. In October 2017 Petitioner was diagnosed with degenerative disc disease and an X-Ray of the cervical spine showed spondylotic changes.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe physical and mental impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint due to any cause), 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), 3.03 (asthma), 9.00 (endocrine disorders), 12.04 (depressive, bipolar and related disorders), and 12.06 (anxiety and obsessive-compulsive disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). This includes

consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3). The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence

or pace; and episodes of decompensation) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. Id. The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. Id.

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical conditions.

Petitioner testified that he can walk two to three blocks then needs to rest due to pain in his back. He stated that he does not use a cane, walker or wheelchair to assist in ambulation. He testified that he can sit for one to three hours and stand for only 10 to 20 minutes. Petitioner testified that he can bend and squat with difficulty and it is painful. He stated that he can slowly climb stairs. Petitioner testified that he can lift a maximum of five pounds and has difficulty gripping and grasping items with his hands because his fingers get numb. He stated that he is able to bathe and dress himself and tend to his own personal hygiene. Petitioner testified that he does not do any household chores including cooking, cleaning, laundry and that his son does everything around the house. He stated that he gets tired as a side effect of his medications and that he is forgetful and unable to focus. Petitioner reported suffering from anxiety attacks, crying spells and having issues with anger. Petitioner reported hallucinations during the night but did not report any suicidal or homicidal ideations. He indicated that his social interaction is limited.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of his symptoms. As referenced above, although Petitioner has medically determinable impairments that could reasonably be expected to produce symptoms, Petitioner's statements about the intensity, persistence and limiting effects of his symptoms are not fully supported by the objective medical evidence presented for review and referenced in the above discussion.

Therefore, based on a thorough review of Petitioner's medical record and in consideration of the above, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

While Petitioner alleged depression and anxiety as mentally disabling and identified symptoms associated with the impairments, based on the medical records provided, Petitioner's anxiety and depression symptoms were responding well to the medication prescribed and throughout the course of his treatment, he seemed to be improving. Based on the medical records presented, as well as Petitioner's testimony, he has mild to moderate limitations on his mental/non-exertional ability to perform basic work activities.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's employment history in the 15 years prior to the application consists of work as a sailor or cook in a naval ship, and as a busboy in a restaurant. Petitioner testified that his past employment required regularly lifting 10 to 20 pounds and standing more than 10 hours per day. Thus, it is characterized as requiring light to medium exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits him to sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, he cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

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

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to

perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

However, when a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. He is not a high school graduate and has limited ability to communicate in English, with unskilled to semi-skilled work history that is not transferable. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. Thus, based solely on his exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as referenced above, Petitioner also has impairments due to his mental condition. As a result, he has a nonexertional RFC imposing mild to moderate limitations in his mental ability to perform work activities. Based on the evidence presented, at this time, it is found that those limitations would not preclude him from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's SDA determination is **AFFIRMED**.

ZB/tlf

Zainab A. Baydoun
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) 763-0155; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email: [redacted]

Petitioner – Via First-Class Mail: [redacted]