STATE OF MICHIGAN
RICK SNYDER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 3, 2018
MAHS Docket No.: 18-005794
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton**

## 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 August 1, 2018, from Detroit, Michigan. Petitioner represented herself. [redacted], Petitioner's caregiver and [redacted], Petitioner's mother, appeared on behalf of Petitioner. The Department of Health and Human Services (Department) was represented by [redacted], Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Records from [redacted] with a cover letter dated August 21, 2018 was received and marked into evidence as Petitioner's Exhibit 1. The record closed on September 11, 2018, and the matter is now before the undersigned for a final determination based on the evidence presented.

## 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 April 5, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 18, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 44-50).

3. On May 24, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 4-10).

4. On June 8, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to colitis, pancreatitis, hepatic steatosis dyspnea, depression, anxiety, bulging disc, diabetics and gastro reflux.

6. On the date of the hearing, Petitioner was [redacted] years old with an [redacted]6 birth date; she is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner is a high school graduate.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as a cashier, stocker and server.

10. Petitioner has a pending disability claim with the Social Security Administration.

## 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 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 (July 2015), 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**,** she is not ineligible under 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, and in response to the interim order, was reviewed and is summarized below.

On March 24, 2017 through April 2, 2017, Petitioner was seen for Alcoholic Hepatitis. Alcoholic Hepatitis was noted to be liver inflammation caused by drinking alcohol. Petitioner's risk factors were noted to be drinking heavily for years; being obese; and infectious hepatitis. (Exhibit A, pp. 792- 834)

On March 29, 2017, Petitioner underwent a CT Abdomen and Pelvis with Intravenous Contrast. The findings relating to the lower thorax included that there was a ground glass infiltrate in the left lower lobe. The findings relating to Petitioner's abdomen indicated that the liver was fatty infiltrated. It was enlarged and measured 24 cm in length. The findings relating to Petitioner's pelvis included that there was a left ovarian cyst measuring 2.5 cm. (Exhibit A, pp. 345-348).

On April 4, 2017, Petitioner was seen with a chief complaint of seizures and possible infection of her right elbow. The record indicated that Petitioner had been recently hospitalized for seizure from alcohol withdrawal. Petitioner indicated that she was feeling well since her discharged. (Exhibit A, pp. 778-781).

On April 11, 2017, Petitioner was seen with a chief complaint of bursitis. Petitioner indicated that her elbow pain had lasted for three to four weeks. Petitioner was not in

distress. Petitioner had tenderness to palpation Olecranon and Olecranon bursa. Flexion, extension, supination, and pronation were listed as mildly decreased. (Exhibit A, pp. 775-776).

On April 21, 2017, Petitioner received an injection to the right elbow. There were no complications with the procedure. (Exhibit A, pp. 773-774).

On May 2, 2017, Petitioner was seen with a chief complaint of seizures. Petitioner appeared well nourished and in no distress. She did not have any neurological focal deficits. Her gait was within normal limits. (Exhibit A, pp. 770-771).

On May 4, 2017, Petitioner was seen [redacted] for a follow up visit relating to her elbow. Petitioner's elbow was improved in forearm. Petitioner was wearing an ace wrap and stated that the Norco helped. Petitioner was not having any seizures. Petitioner was not drinking at all at the time of this visit. (Exhibit A, pp. 309-315).

On November 15, 2017, Petitioner was seen with a chief complaint of elbow pain. It was noted that Petitioner had pancreatitis flare when she was downstate; however, no time frame was given. Petitioner did not seek medical treatment at that time. Petitioner was also having leg cramps at the time of the visit. Petitioner was noted to have tenderness palpation in medial epicondyle, lateral epicondyle; and olecranon. Petitioner had full range of motion bilaterally. Her muscle strength was 5/5 bilaterally. (Exhibit A, pp. 755-758).

On November 28, 2017, Petitioner was seen with chief complaints of back pain and anxiety. Diagnoses included: hyperglycemia, unspecified; anxiety disorder, unspecified; disease of pancreas, unspecified; dorsalgia, unspecified; and pain in right elbow. (Exhibit A, pp. 751-754).

On January 16, 2018, Petitioner was seen with a chief complaint of diabetes and elbow pain. Diagnoses included anxiety disorder, unspecified; vitamin D deficiency, unspecified; and Type 2 diabetes melitus without complications. (Exhibit A, pp. 746-750).

On January 19, 2018, Petitioner was seen by [redacted] Petitioner had good cervical range of motion; Spurling's maneuver to the right increased her neck and trapezius pain but did not radiate down the arm. She had good range of motion of the shoulders, elbows, wrists and digits. Impingement maneuvers were negative. Petitioner had no instability of the elbows or shoulders. Phalen's maneuver was negative bilaterally, but she did experience paresthesias in the right hand in the fifth digit. Tinel's at the elbow was negative. Reflexes were symmetric at 2+ in the triceps. The right biceps were absent while the left was 1-2+. There was no definite focal weakness, but perhaps some slight weakness in the pronation and supination on the right side compared to the left. Petitioner did not state that the pain was limiting her effort. Sensory evaluation did not reveal any focal pinprick deficits. Petitioner had no adenopathy or edema. Right

elbow X-rays were unremarkable. Diagnoses included cervicalgia and pain in right arm. (Exhibit A, pp. 277-278).

On January 30, 2018, Petitioner had an MRI of the cervical spine. Findings included that there was significant arthropathy with signal change noted and narrowing of the intervertebral disc space at the C5-C6 level. There was no evidence of bone bruise or marrow edema. There was normal signal in the cervical cord. The cerebellomedullary junction was unremarkable, and cerebellar tonsils are in normal location. (Exhibit A, pp. 716-717).

On January 31, 2018, Petitioner was seen at the [redacted] with problems relating to her feet and lower legs as well as being recently diagnosed as diabetic. There was mild edema of the lower legs. The neurologic, light touch and protective sensation appeared to be intact. The muscle tone appeared to be adequate in all directions. The biomechanical showed good alignment of the feet. There were no obvious mechanical deformities. Petitioner's range of motion seemed adequate for ambulation in the major joints. The assessment included: onychomycosis; onychocryptosis left great toe; tinea pedis moccasin distribution type bilateral; and venous insufficiency bilateral. (Exhibit A, pp. 1054-1056).

On February 1, 2018, Petitioner was seen at [redacted] with a chief complaint of diabetes and blurred vision. Assessment was as follows: diabetes, non-insulin dependent w/o complication; no diabetic retinopathy; and no diabetic macular edema. (Exhibit A, pp. 723-726).

On February 21, 2018, Petitioner was seen by [redacted]. Following the examination, there was no weakness or atrophy in the and muscles noted or any new changes in the right elbow. Spurling's maneuvers elicited neck pain without reproducing much in the way of back pain. Petitioner's cervical MRI was reviewed. The most significant changes were noted at C5-6. There was some mild narrowing of the exit pathway of the C6 nerve root on the right. The impression was cervical radiculopathy. (Exhibit A, pp. 274-275).

On February 28, 2018, Petitioner underwent an esophagogastroduodenoscopy (EGD) to examine the lining of your esophagus, stomach, and duodenum. The impressions were as follows: slightly irregular Z-line s/p biopsies to rule out short segment Barret's esophagus metaplasia mild antral and gastric erythema s/p biopsies to rule out H. pylori. Also, on February 21, 2018, Petitioner underwent a colonoscopy. The impressions were as follows: normal terminal ileum; ascending colon 0.4 cm polyp s/p cold snare polypectomy; transverse colon pedunculated 1.2 cm polyp s/p cold snare polypectomy; normal colonic mucosa s/p right and left colon biopsies to rule out microscopic colitis; small internal hemorrhoids and small external hemorrhoids. (Exhibit A, p. 711-712).

On March 30, 2018, Petitioner was seen by [redacted] and presented for follow up regarding her neck. Petitioner had an epidural injection which caused increased pain in

her neck for about two weeks. After the two weeks, she felt better. Petitioner did not have any bowel or bladder incontinence; no constipation; no problems with shortness of breath; no palpitations or chest pains; no difficulty sleeping and no fever or chills. Petitioner's cervical radiculopathy was noted as improving. (Exhibit A, pp. 272-273).

On April 10, 2018, Petitioner had a cervical epidural steroid injection. Petitioner reported mild improvement in pain level following the most recent prior injection of March 1, 2018. Petitioner tolerated the injection well. (Exhibit A, pp. 279-280).

On April 25, 2018, Petitioner was seen by [redacted] and presented with neck and arm pain. Petitioner had a second cervical epidural which she stated went much better. Petitioner stated that she did not achieve complete pain relief, but she did not have the severe pain reaction that occurred with the first epidural. Petitioner's upper extremity strength was decent. There was no focal weakness and no atrophy observable. (Exhibit A, pp. 269-271).

On May 8, 2018, Petitioner was referred for a psychological evaluation by DDS. Petitioner reported having PTSD, depression and anxiety. Petitioner's medical history included symptoms of pancreatitis as well as Type 2 Diabetes and GERD. The Medical Source Statement, following the examination, stated that Petitioner appeared to be cognitively functioning within the average to low average range of intellectual abilities. Petitioner presented with moderate symptoms of anxiety with those symptoms causing a moderate impairment in her ability to prosocially interact, concentrate, or remember complex job tasks. The psychologist believed that Petitioner would be able to understand and retain, and follow simple instructions, those consistent with her work history. It was noted that given Petitioner's symptoms anxiety and depression, she could experience moderate to marked impairment in understanding and completing more complex tasks, those being more than 3-4 in nature. Petitioner's diagnosis included generalized anxiety disorder, moderate in severity; other specified depressive disorder with recurrent brief depression; and alcohol use disorder, moderate in severity being in self-reported early remission which was noted to need further evaluation. (Exhibit A, pp. 254-262).

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 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 1.04 (disorders of the spine); 5.05 (chronic liver disease); 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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). For the first three functional areas, a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she could dress/undress herself; bathe/shower herself; use the bathroom; eat by herself; squat; bend at his waist; reach; walk; sit; kneel; climb stairs; and use his hands. Petitioner indicated that she is unable to stand for more than 10 minutes without experiencing pain.

Petitioner testified that she has experienced some memory loss stemming from her placement on a ventilation in January 2016. Petitioner listed her ability to concentrate as "so so." Petitioner testified that she finds completing tasks to be painful. Petitioner indicated that she is able to work with others.

Petitioner's caregiver testified that she has side effects from her medication and she has bouts with confusion. [redacted] further testified that Petitioner will start chores, but he typically has to finish the chores. He testified that her appetite fluctuates. [redacted] testified there are occasions when Petitioner will become constipated and then she will experience diarrhea for a day or two. Mr. Birdsong testified that the furthest he

is able to get Petitioner to walk without experiencing pain is approximately one block. He indicated that Petitioner has fallen three times in the last three months.

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. Petitioner testified that her diabetes causes her to be unable to work only when she has a flare up. Likewise, Petitioner stated that when she has a flare up with pancreatitis she is unable to work. Petitioner stated that she has six bulging discs. Petitioner also testified that she has uncontrollable vomiting. On August 21, 2018, Petitioner's doctor indicated that Petitioner was treating with her for diabetes, chronic pancreatitis and low back.

When Petitioner was seen on March 30, 2018, a week prior to her application, she did not have any bowel or bladder incontinence; no constipation; no problems with shortness of breath; no palpitations or chest pains; no difficulty sleeping and no fever or chills. Petitioner's medical records to do show any significant treatment for uncontrollable vomiting.

Petitioner testified that depression and anxiety limit her ability to work. However, the medical records provided within the year prior to Petitioner's application, do not show any significant treatment for depression or anxiety. There is no indication that Petitioner is regularly treating with a psychiatrist or therapist. Petitioner's results relating to her elbow pain reveal that she has good range of motion and that, although she is not completely pain free, her condition improves with injections.

Additionally, the May 8, 2018 consultation noted that Petitioner had a moderate impairment in her ability to prosocially interact, concentrate, or remember moderately complex job tasks. Further, while there was a moderate to marked impairment to complete more complex task, she was found to be able to understand and retain, and follow simple instructions, those consistent with her work history as a cashier and shelf stocker.
There is no medical evidence to support any exertional limitations. Further, based on the medical records presented as well as Petitioner's testimony, he has moderate limitations on her mental/non-exertional ability to perform basic work activities. In Petitioner's past relevant work, she engaged in simple, unskilled work activities. It is found that Petitioner is able to perform past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

## DECISION AND ORDER

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.

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

JAM/tlf

**Jacquelyn A. McClinton**
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]