[redacted]

Date Mailed: September 17, 2018
MAHS Docket No.: 18-006479
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Alice C. Elkin

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 20, 2018, from Detroit, Michigan. Petitioner appeared and represented herself. The Department of Health and Human Services (Department) was represented by [redacted], General Special Program Manager, and [redacted], Eligibility Specialist.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of 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 3, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On June 28, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 7-13, 14-50).

3. On June 28, 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. 4-5).

4. On June 28, 2018, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-3).

5. Petitioner alleged disabling impairment due to attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), chronic back pain, chronic migraines, and vertigo (Exhibit A, p. 58).

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted] birth date; she is 5'4" in height and weighs about 195 pounds. She had gained 50 pounds over the course of the preceding year.

7. Petitioner is recipient of a general education degree (GED) and an associate degree.

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

9. Petitioner has an employment history of work as factory worker.

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 (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, 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 medical evidence presented at the hearing was reviewed and is summarized below.

In notes from a February 7, 2017 office visit with her primary care physician, Petitioner complained of ongoing migraines since age 16 when she had a head injury and low back pain that began three months ago and was triggered by lying down for more than 30 minutes or sitting for long periods of time. She reported headaches three to four times per month with an aura of light on the left but no numbness, weakness or tingling and no dizziness, light-headedness, speech difficulty, loss of consciousness, seizures, tremors, or numbness/tingling or weakness. She reported PTSD and depression treated by a counselor but no current suicidal or homicidal ideation or sleep disturbance, hyperactivity, behavioral problems, or decreased concentration. A straight leg raise was negative for pain, and her back pain was deemed most likely musculoskeletal. It was noted that her mood did not appear anxious and she did not exhibit a depressed mood. She was referred to neurology for her migraines and to physical therapy for her low back pain and prescribed duloxetine for her PTSD and depression (Exhibit A, pp. 188-194).

The primary care doctor's April 12, 2017 progress notes show that Petitioner had three migraines over the past three months but was able to treat them immediately with propanol and Imitrex. She was unable to participate in physical therapy for her back pain due to lack of finances. (Exhibit A, pp. 195-198.)

A September 6, 2017 lumber spine x-ray showed mild anterolisthesis of L5 relative to S1 with associated facet joint sclerosis at the L5-S1 level and to a lesser extent at L4-L5, but no definite spondylosis. The impression was degenerative changes in the lower lumbar spine with mild anterolisthesis of L5 on S1, with no acute change from May 18, 2017. (Exhibit A, p. 258.)

On November 17, 2017, Petitioner went to the emergency department complaining of dizziness with no pain, headache, chest pain, cough or shortness of breath. There was no history of similar complaints and no preceding trauma. She had some slight nausea but it did not cause vomiting. She was found to be afebrile and did not appear to be ill, toxic or in distress. Petitioner's November 17, 2017 electrogram (ECG) showed no acute ischemic change or rhythm abnormality. She was diagnosed with acute benign positional vertigo and normotensive. She was advised to refer to her primary care physician if having mild continuation of symptoms. She was discharged in stable condition. (Exhibit A, pp. 96-105.)

In a November 20, 2017 follow up with her primary care doctor, Petitioner reported some improvement in her dizziness but continued symptoms with sudden movement and sudden change in position. The doctor concluded that it was unlikely that her head injury 25 years ago contributed to her current vertigo symptoms and, finding no other red flag symptoms such as numbness, tingling, or weakness, concluded that additional imaging was not necessary. (Exhibit A, pp. 224-230).

In a November 30, 2017 office visit with her primary care doctor, Petitioner reported an onset of vertigo 20 years ago after a head injury with black-outs, light-headedness, spinning, and headaches, aggravated by stress. She also reported PTSD due to imprisonment for over 20 years and ADHD aggravated by stress and tasks requiring attention to detail. The doctor's assessment indicated mood disorder and possible ADHD. Because of syncope and collapse and a history of head injury, with pain in back part of head radiating to neck and back, a brain MRI was ordered. (Exhibit A, pp. 111-115.) A December 6, 2017 brain MRI was negative for acute change but showed a small encephalomalacia defect within the posterior left frontal lobe and the anterior left parietal lobe, most likely representing a sequelae of prior trauma or ischemia (Exhibit A, pp. 117-118, 183-184).

On December 13, 2017, Petitioner returned to the emergency department, complaining of dizziness, throbbing headache, and two episodes of vomiting overnight. There were no reported visual changes, difficulty speaking or swallowing, neck pain, shortness of breath, abdominal pain, diarrhea, weakness or numbness in arm or legs. She was given fluids, Toradol, Benadryl and reglan, which resolved her headache and eased her dizziness, making her able to ambulate without difficulty. It was found that no neuroimaging was required and she would return for vertigo therapy the next day. (Exhibit A, pp. 170-171.)

On December 22, 2017, Petitioner went to her primary care doctor complaining of neck pain and dizziness after her husband grabbed her by the hair and whipped her head around at least three times. She was diagnosed with acute strain of her neck muscle and referred to physical therapy for the cervical strain in addition to the treatment she was receiving for dizziness. (Exhibit A, pp. 236-257.)

Progress notes from counseling sessions at Untangled counseling evidence attendance from March 27, 2018 to June 6, 2018 (Exhibit A, pp. 130-143.)

On February 23, 2018, Petitioner went to the emergency department because of a cough that had continued for a week. It was found that the symptoms were likely viral, and she was diagnosed with acute sinusitis. (Exhibit A, pp. 168-169.)

On April 17, 2018, Petitioner went to the emergency department alleging back pain for three days that wrapped around her upper stomach with occasional shortness of breath and nausea that began two days after starting a new exercise program. A physical exam showed regular heart rate and rhythm, full range of motion of the extremities;

excellent strength, sensation, and reflexes throughout the upper and lower extremities but full reproduction of her back discomfort with sitting forward and twisting or turning. An EKG was normal-appearing. Her x-rays were unremarkable. The doctor concluded that the range-of-motion related symptoms pointed towards a musculoskeletal source and he recommended ibuprofen and Norflex. (Exhibit A, pp. 164-165.)

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), 11.18 (traumatic brain injury), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.11 (neurodevelopmental disorders), 12.15 (trauma and stressor-related 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). A five-point scale is used to rate the degree of limitation in each area: 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 lived alone and handled her own bathing and personal hygiene. She could dress herself. Because of her vertigo, she limited her driving. She relied on her niece and nephew's help with chores and shopping. She did not have difficulty walking, although sometimes it was hard to get up. She could sit for up to an hour with a pillow behind her back, less without a pillow. She could lift 15 to 20 pounds. She tried to limit the time she spent standing. Her migraines resulted in blurred vision and auras. She feels anxious and fidgety, particularly around people, and her mood could result in lying in bed for two weeks. Crowds triggered thoughts of her incarceration.

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.

In this case, the September 6, 2017 lumbar spine x-ray showed degenerative changes in the lower lumbar with mild anterolistehsis of L5 on S1. A December 6, 2017 brain MRI was negative for acute change but showed a small encephalomalacia defect within the posterior left frontal lobe and the anterior left parietal lobe, most likely representing a sequelae of prior trauma or ischemia. Petitioner was prescribed medication to treat PTSD and depression and was assessed with mood disorder and possible ADHD. She went to the doctor complaining of vertigo and migraines. Thus, there were medically determinable impairments to supporting Petitioner's mental conditions, low back pain, vertigo and migraines.

With respect to the headaches, the office visit notes show that Petitioner reported headaches three to four times month with an aura of light on the left but no numbness, weakness or tingling and no dizziness, light-headedness, speech difficulty, loss of consciousness, seizures, tremors, or numbness/tingling or weakness. Petitioner went to the emergency department on December 13, 2017 complaining of dizziness, throbbing headache and two overnight episodes of vomiting but no reported visual changes, difficulty speaking or swallowing, neck pain, shortness of breath, abdominal pain, diarrhea, weakness or numbness in arm or legs. The treatment resolved her headache and eased her dizziness, making her able to ambulate without difficulty. In a November 20, 2017 office visit, Petitioner's primary care doctor opined that there were no other red-flag symptoms such as tingling, numbness or weakness. Her last physical exam on April 17, 2018 showed full range of motion of the extremities and excellent

strength, sensation, and reflexes throughout the upper and lower extremities, and the x-rays and EKG were unremarkable, leading the doctor to conclude that back pain was musculoskeletal source.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record, including Petitioner's testimony, that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has nonexertional limitations due to her vertigo that limit her from working on elevated surfaces or from driving. She has limitations on her mental ability to perform basic work activities as follows: mild limitations in ability to understand, remember or apply information; moderate limitations in ability to interact with others; mild limitations in ability to concentrate, persist, or maintain pace; and mild limitations in ability to adapt or manage oneself.

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 work history in the 15 years prior to the application consists of intermittent factory work, which required standing all day and lifting up to 20 pounds regularly. However, it is found that Petitioner's limited work history did not constitute SGA. Because Petitioner lacks past relevant work, Petitioner 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). 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, 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). 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 at the time of hearing, and, thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She has a GED and an associate degree. Her limited work history involves unskilled labor. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities but she also has nonexertional RFC that limits her from working on elevated surfaces or from driving and that results in mild limitations in ability to understand, remember or apply information; moderate limitations in ability to interact with others; mild limitations in ability to concentrate, persist, or maintain pace; and mild limitations in ability to adapt or manage oneself

Based solely on her exertional RFC, the Medical-Vocational Guidelines, 202.20, result in a finding that Petitioner is not disabled. Petitioner's nonexertional limitations do not preclude her 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.

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.**

AE/tm

Alice C. Elkin
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

DHHS [redacted]

Petitioner [redacted]

cc: [redacted]