

2. On May 28, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 200-206).
3. On July 16, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 208-212).
4. On July 23, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 213).
5. Petitioner alleged disabling impairment due to mental impairment due to bipolar disorder with severe anxiety and depression. The Petitioner alleged physical disabling impairment due to lumbar spine pain, fibromyalgia, varicose veins which cause severe pain and carpal tunnel in her hands. The Petitioner is also obese.
6. On the date of the hearing, Petitioner was [REDACTED] years old with a [REDACTED] birth date; she is [REDACTED] in height and weighs about [REDACTED] pounds.
7. Petitioner completed the 8th grade and was enrolled in special education classes from kindergarten on.
8. At the time of application, Petitioner was not employed.
9. Petitioner has an employment history of work as a security guard, a dishwasher, a fast-food cashier and she also took orders and was responsible for clean-up. The Petitioner also was employed with Walmart as a stock clerk.
10. At the conclusion of a Mental Status Examination arranged for by the Disability Determination Service conducted on [REDACTED] 2019, the examiner found that the Petitioner's ability to understand, remember and apply information was mildly impaired by her difficulties with reading and mathematics. Her ability to work persistently at an acceptable pace and to attend to work throughout a full day is moderately to severely impaired by her emotional difficulties. Her dissociative disorder may cause significant workplace problems with memory impairment and behavioral abnormalities. Chronic pain problems may limit her ability to perform many full-time jobs. Petitioner's ability to interact with others appropriately in job settings is moderately to severely impaired. She has had significant anger control issues which often led to her being fired or to terminate jobs. Her ability to adapt to work changes and utilize public transportation, travel on to unfamiliar places and set realistic goals was mildly to moderately impaired; her prognosis was determined as poor to fair. Exhibit A, pp. 122-123.
11. 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 90 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 1

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 2

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 [REDACTED] 2019, the Petitioner participated in an independent Mental Status Examination requested by the Disability Determination Service. The Petitioner advised the examiner that she had depression, anxiety and bipolar disorder, personality disorder and dyslexia and learning disabilities. Petitioner reported decreased energy, interest and enjoyment of life. She described herself as having low self-esteem. She isolates herself except with her father and sisters. Her appetite fluctuates widely. Petitioner reported that prior to being prescribed sleep medications, she would sometimes not sleep for days and then sleep for 24 hours. Even with the medications for sleep the Petitioner reports approximately four hours sleep a night. She expressed that she has suicidal ideations often and crying spells. She reported many suicide attempts beginning at age seven, including overdoses, hanging attempts, jumping off a building, cutting herself and attempting to be hit by a car. She also expressed homicidal thoughts regarding her father and brother. She admitted to attempting to stab her father with a butcher knife resulting in a psychiatric hospitalization. She described multiple attempts to stab her brother using a screwdriver, a paring knife and plastic utensils. He apparently did not require any surgery from superficial stabbings.

The examiner's notes indicate that the Petitioner described a pattern consistent with a dissociative identity disorder. The examiner noted that she may have periods of amnesia where she has other personalities emerge. Several examples of such personalities were by Petitioner, such as [REDACTED] who is rude and blunt and also stabbed her father. Another is [REDACTED] who is quiet, likes to care for children and is clean. A third personality is male in gender and is [REDACTED] who Petitioner described as being there when she needs him. The Petitioner also described hearing voices associated with bad people and describes having auditory hallucinations daily which tell her to do things, such as drink bleach and that she is worthless. She reports amnesia when the other personalities emerge and reports others tell her how she behaved and has no memory of those times. Petitioner also reports stress seizures described in the report as nonepileptic psychogenic in nature. She indicated that during a seizure she may lose consciousness. Workup for epilepsy has been negative. The last such seizure was over a year ago. The Petitioner reported problems with both reading and math and had to repeat grades 7 and 8. Petitioner completed the 8th grade and has made unsuccessful attempts to complete a GED.

The report indicates outpatient treatment downstate at [REDACTED]. She also had treatment at age [REDACTED] at [REDACTED] and

continuing until about two years ago. Petitioner reported trust issues due to her therapist trying to hospitalize her causing Petitioner to terminate her treatment. Her current medication for depression, Trintellix, has helped some. The Petitioner reported nine hospitalizations (institutional) at [REDACTED] in [REDACTED] Michigan, and [REDACTED] Michigan. These occurred when she was [REDACTED] or [REDACTED] years old. Petitioner also reported several physical illnesses/conditions including migraine headaches, arthritis in her back, knees and hands, asthma, COPD and obesity. She also reported herniated cervical disks, neuropathy and fibromyalgia.

Petitioner also reported heavy alcohol use in 2009 and reported using marijuana and has a medical marijuana card. Petitioner reported no current use of alcohol or other street drugs. Petitioner also reported being sexually abused by her brother during much of her childhood until age [REDACTED] when it stopped.

Petitioner also reported losing her employment due to back problems and difficulty with co-workers and supervisors telling her how to do something, reporting she would get mad or curse and walk off the job or get fired.

Petitioner has had her three eldest children removed and each of her next four children were taken away at birth by protective services. Petitioner also reported ability to perform simple cooking in a microwave and some occasional light housekeeping. She does not drive in the winter and said she could handle money if she had any.

The Petitioner's affect during the examination was described as mildly depressed, and her affect was appropriate to her thought content. She was oriented to time and place and spoke at a normal rate and volume and was cooperative. She could not do most of the math calculations except for simple subtraction and addition. Petitioner was able to write a simple sentence correctly and read a brief paragraph correctly but held it upside down to do so which she described as typical.

The Medical Sources Statement concluded that Petitioner was generally sincere in describing her symptoms and problems and in the performance of mental status tasks. The report noted some of the claims seemed unusual such as stabbing her brother over 300 times. The Petitioner's ability to understand, remember and apply information is mildly impaired by her difficulties with reading and mathematics. The Petitioner's ability to work persistently at an acceptable pace and to attend to work throughout a full day is moderately to severely impaired by her own emotional difficulties. Her depression depletes her energy. Her dissociative disorder may cause significant workplace problems with memory impairment and behavioral abnormalities. In addition, her chronic pain problems may limit her ability to perform many full-time jobs. The Petitioner's ability to interact with others appropriately in the job setting is moderately to severely impaired. She has had some significant anger control issues which have often led her to be fired or to terminate jobs. The Petitioner's ability to adapt to work changes, utilize public transportation travel to unfamiliar places and set realistic listing goals is mildly to moderately impaired. Petitioner's prognosis for improvement is poor to fair. It

is possible some of her symptoms could improve with optimum pharmacotherapy and some intensive psychotherapy. However, she has had extensive psychotherapy in the past only to leave treatment with issues of lack of trust. The examiner's diagnosis was schizoaffective disorder, depressive sub-type, dissociative identity disorder, unspecified personality disorder primary cluster B, conversion disorder namely psychogenic nonepileptic seizures, alcohol use disorder, moderate in remission, with medical problems which include spinal arthritis and disc disease, possible neuropathy and fibromyalgia with chronic pain, obesity, migraine headaches, gastroesophageal reflux disease, anemia, asthma and COPD.

The Petitioner is seen regularly by her primary care physician and was last seen on [REDACTED] 2019, based on the medical records available. The active problems noted in the medical records will included anxiety, arthralgia of the ulna and radius of her left wrist, chronic low back pain, bipolar disorder, chronic obstructive pulmonary disease, chronic pain, depression edema, fibromyalgia, nicotine dependence, obesity, patellar chondromalacia left, social phobia and stomatitis. At the time of the appointment, she had reported diffuse feelings of lightheadedness and dizziness. She reported experiencing a racing heart pulsating into the neck area with shortness of breath. Patient reported she had anywhere between one through seven episodes a day lasting approximately 30 to 40 seconds per episode. Also reported was ongoing bilateral wrist pain and sores on her tongue extending into her throat with unknown exposure without open lesions. The current medications were too numerous to list but included medications for her mental anxiety depression, asthma COPD. Her diagnosis included asthma, non-organic sleep apnea, hepatitis B, arthritis, migraine headache, psychiatric disorders, depression, anxiety, anemia arthritis, chronic back pain and varicose veins. At the time of the exam, the Petitioner's weight was [REDACTED] pounds with a body mass index of 50.9. Also reported was back pain at a pain level of 7/10. At the conclusion of the exam, the doctor determined that there was pain in the left wrist, major depressive disorder and generalized anxiety disorder and dizziness. The doctor prescribed a Holter monitor for 30 days to rule out any problems, and all other medications were continued; a referral for EMG testing was prescribed.

In [REDACTED] 2019, the Petitioner was seen by her primary care physician with complaints of low back pain with burning in both her legs with complaints of dizziness and bilateral ear pain. Her medications were continued; the diagnosis remained essentially the same; and Petitioner was referred to physical therapy for rehabilitation for low back pain. The Petitioner has had prior referrals to pain clinic for pain management. The Petitioner has been seen for this condition since 2018 and has been prescribed Neurontin as well as lidocaine patches for pain relief as well. In addition, the primary care doctor ordered a brace for her right knee and bilateral ankles at a visit in [REDACTED] 2018. In [REDACTED] 2018, her primary care doctor also prescribed medications for generalized anxiety disorder, Vistaril, major depressive disorder, Trintellix, and Neurontin for chronic pain.

The Medical records indicate that Petitioner was diagnosed with circadian rhythm sleep disorder and obstructive sleep apnea on [REDACTED] 2018. This was diagnosed due

to an office visit for sleep disturbance and pulmonary problems at the Center for Pulmonary And Sleep Medicine. A sleep study was prescribed at the conclusion of the exam.

The Petitioner was seen at [REDACTED] Healthcare on [REDACTED] 2018, and was seen by a sleep specialist due to sleep apnea as well as migraine headaches. The Petitioner was prescribed medication maxalto for migraine headaches. The Petitioner was also seen by [REDACTED] Ear, Nose and Throat PC on [REDACTED] 2018 at which time she was diagnosed with GERD, and the recommendation was bariatric surgery and possible hiatal hernia. The Petitioner also had a tube placed in her right ear on September 16, 2018. The ENT also diagnosed chronic pharyngitis, and gastroesophageal reflux disease without esophagitis.

The Petitioner was seen on [REDACTED] 2018, for a follow-up due to a right ankle injury and was prescribed an ortho boot for ambulation. An x-ray of the ankle was taken for possible nondisplaced fracture of the distal fibula of the right ankle. The assessment was unspecified fracture of shaft of right fibula, subsequent encounter for closed fracture with routine healing. The plan was that patient was to continue to wear the boot, ice and elevate right foot and prescribed Tylenol/Motrin as needed for pain.

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 3

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 12.03 Schizophrenia spectrum and other psychotic disorder and 12.04, bipolar and related disorders regarding Petitioner's mental impairments and 1.04, Disorders of the Spine 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 (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) 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 non-exertional limitations due to her medical condition. Petitioner testified that she could stand for 15 minutes due to her back pain and sit for approximately 30 minutes with pain. She uses a cane and could not describe how far she could walk. She could not perform a squat and had difficulty bending sideways and backwards but could bend forward only. She could also shower and dress herself and wore slip-on shoes due to inability to tie her shoes and could not touch her toes. The Petitioner also testified that she had carpal tunnel syndrome in her right hand making it difficult to write for long periods, and with regard to her legs and feet, experience pain and numbness due to neuropathy. The Petitioner estimated she could carry approximately seven pounds.

As regards her mental impairments and diagnosis, Petitioner testified that she has significant trouble getting along with authority and basically hates people. She described stabbing her brother several times in the past and experiences voices telling her to hurt herself in the past. She has pseudo seizures, which she attributes to emotional stress; the last one occurring approximately a year ago. Petitioner admitted issues with alcohol a long time ago but has not experienced any problems currently. Her sister also attended the hearing and indicated that she has serious difficulties with her behavior. The Petitioner indicated that she experiences anxiety most of the time, which she described as very high with ongoing crying spells. The Petitioner has anger issues and describes involvement with fist fights. At night, she describes seeing shadows. As regards her eating habits, she of late has had to force herself to eat and testified that her memory and concentration are variable depending on her mood and

emotional condition on a given day. Her dissociative disorder may cause significant workplace problems with memory impairment and behavioral abnormalities. The Petitioner has no friends and has very few social encounters outside of her father and sister. She has had multiple hospitalizations due to her mental problems.

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.

With respect to Petitioner's exertional limitations, it is found, based on a review of the entire record, that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate to severe limitations on her mental ability to perform basic work activities. At her mental status examination referenced earlier in this Hearing Decision, there was evidence that the Petitioner's mental disorder does interfere with her ability to function independently and appropriately on a sustained basis and her dissociative disorder may cause significant workplace problems with memory impairment and behavioral abnormalities. Her ability to interact with others and concentrate, persist or maintain pace while employed was noted by the examiner as moderate to severe. In addition, he found that Petitioner's issues with authority and anger have caused her to be fired or leave a job in the past. Clearly the evidence supports that the Petitioner has chronic mental disorders including severe anxiety. It is also likely that the Petitioner would have difficulty managing herself depending on her mental condition.

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

Step 4

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 employment history as a security guard, a dishwasher, a fast food cashier, and also took orders and

was responsible for clean up. The Petitioner also was employed with [REDACTED] as a stock clerk. The Petitioner testified that all of these jobs require standing most of the workday as well as required in some positions cleanup work and walking long distances and handling stock involving lifting and carrying.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. Petitioner also has mental limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's non-exertional RFC prohibits her from performing past relevant work.

Because Petitioner is unable to perform 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). *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 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 18-44) for purposes of Appendix 2.

Petitioner has an 8th grade education with a history of unskilled work experience as a security guard, fast food cashier, stocking clerk and dishwashing at a restaurant. 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.

The Medical-Vocational Guidelines, Rule 201.24, does not result in a disability finding based on Petitioner's exertional RFC. However, Petitioner also has impairments due to her mental condition. As a result, she has a non-exertional RFC imposing mild limitations in her activities of daily living; moderate to severe limitations in her social functioning and ability to respond appropriately to supervision and interact appropriately with co-workers and moderate to severe limitations on her ability to maintain pace, and persist and adapt or manage herself. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of her non-exertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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 disabled for purposes of the SDA benefit program.

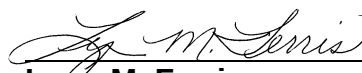
DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's January 7, 2019, SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;
2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;
3. Review Petitioner's continued eligibility in October 2020.

LMF/jaf



Lynn M. Ferris

Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS (via electronic mail)

Amy Assante
MDHHS-[REDACTED] Hearings
BSC1
L Karadsheh

Petitioner (via first class mail)

[REDACTED]
[REDACTED]
[REDACTED] MI [REDACTED]