STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

Date Mailed: April 3, 2020
MOAHR Docket No.: 20-000206
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on February 6, 2020, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Leonard Garza, Family Independence Manager.

ISSUE

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

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On or around 2019, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp. 16-20)

2. On or around 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 33-53)

3. On or around , 2019, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled. (Exhibit A, pp. 11-15)

4. On 2020 Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner's case file indicates she also requested a hearing to dispute the Department's actions with respect to the Family Independence Program (FIP). However, Petitioner confirmed that there was no issue concerning her FIP benefits as the box was checked in error, and thus, the request for hearing was withdrawn and will be dismissed.

6. Petitioner alleged disabling impairments due to closed head injury, fibromyalgia, nerve pain, multiple sclerosis, post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), anxiety, depression, bipolar disorder, and borderline personality disorder.

7. As of the hearing date, Petitioner was 36 years old with a [redacted], 1984 date of birth; she was 5'3" and weighed 190 pounds.

8. Petitioner obtained a high school diploma and has employment history of work at the deli counter in a grocery store, a cook/waitress, and a food expediter at a restaurant. Petitioner has not been employed since [redacted] 2018.

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

CONCLUSIONS OF LAW

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

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below. It is noted that Petitioner testified to having underwent a 90-hour EEG testing in the month prior to the hearing, and a mental status evaluation. However, the medical records for which may not have been included in the Department's Exhibit A, pp. 1-670 admitted into the record during the hearing. Petitioner was given the opportunity to have the record in this matter extended in order to allow her additional time to submit the update medical documentation to the undersigned ALJ; however, Petitioner elected not to extend the record and thus a decision will be made based on the evidence presented during the hearing.

Records from Petitioner's ████ 2019 through ██████ 2019 treatment at ████ ████████████████ were reviewed and show that she was receiving psychiatric, nursing, case/care management, and therapy services for diagnosis of major depressive disorder, recurrent episode; severe, PTSD, generalized anxiety disorder, bipolar I disorder, borderline personality disorder, ADHD, circumstances related to child sexual abuse, and history of traumatic brain injury. (Exhibit A, pp. 627-670). Records indicate that Petitioner was admitted to the hospital in █████ 2019 due to cutting herself and required nine sutures. EMS was called to transport her to the hospital, and she was so agitated in the ER, that she required restraints. During a ████ 2019 assessment, Petitioner reported history of physical and extreme sexual abuse for many years during her childhood, a result of which she now experiences flashbacks, is easily startled, hypervigilant, and suffers from panic attacks and identified symptoms of anxiety. She disclosed symptoms of depression including tearfulness, loss of interest, inappropriate guilt and hopelessness, worthlessness, and insomnia. A

history of self-harming and suicidal behaviors such as cutting were noted. Medication Review notes from a [redacted], 2019 visit indicate that Petitioner reported having episodes of panic attacks and anxiety that are getting worse. She reported that she fell and broke her Achilles tendon and is now required to wear a boot. Petitioner reported that her ADHD is out of control and she is having difficulty focusing and completing tasks. Her mood was frustrated, her affect dysphoric at times but mobile, her psychomotor activity was agitated, her judgment/insight and attention were noted to be fair. In [redacted] 2019, Petitioner reported high anxiety and panic, as well as a lot of pain due to a pinched nerve under her shoulder blade. She indicated that her ex was threatening to take their child from her, and her insight and judgment were noted to be fair to limited. (Exhibit A, pp. 627-670).

On [redacted], 2019, Petitioner was brought to the Emergency Department at [redacted]l via EMS for a psychiatric evaluation. Per EMS, they were contacted after Petitioner sent a photograph of her cut wrist to her boyfriend who contacted 911. EMS reported that Petitioner was agitated and uncooperative and rude to the hospital staff. While at the hospital, Petitioner denied current suicidal ideation but stated that she cuts herself to relieve her emotional pain. Petitioner was admitted for psychiatric treatment through [redacted], 2019. Petitioner was administered medication as she was uncooperative during attempts to repair her wrist. There was a linear laceration to the mid anterior wrist, the laceration was from the distal rest, the cut was directionally towards the maximal rest at the midline. The wound was repaired with eight interrupted sutures after Petitioner was given sedatives. Petitioner was admitted for psychiatric treatment through [redacted] 2019. She reported history of suicide attempts including one in [redacted] 2014 by overdose of medications because her son said something that upset her and indicated that she couldn’t stand the thought that she “had given birth to something so evil.” She reported a second suicide attempt years before using the same method because she was kidnapped, and people did not believe her. She reported that her children are under guardianship with her mother and sister. A history of cutting behavior was also reported. Examination revealed that her concentration/attention span was impaired, her intelligence was below average based on history, vocabulary, syntax, grammar and content, her judgment and insight were poor and it was noted that she had limitations including medication noncompliance, pathological/unsupported environment, intellectual impairments as a result of a head injury and from a traumatic brain injury. A petition for involuntary stay and a second certification for involuntary admission to the psychiatric unit were filed. Petitioner demonstrated a lack of insight and poor coping mechanisms. Her inpatient treatment was justified due to her noted agitation, anxiety, and depression resulting in significant loss of functioning; her being dangerous to herself with need for a controlled environment; emotional or behavioral conditions and complications requiring 24 hour medical and nursing care; need for special drug therapy or other therapeutic program requiring continuous hospitalization; failure of social or occupational functioning; an inability to meet basic life and health needs making this admission legally mandated. Progress notes from [redacted], 2019, during Petitioner psychiatric hospitalization, indicate that Petitioner had difficulty sleeping, continuing to be depressed and suicidal,

but had no current harm to herself. Notes indicate that she remained anxious and displayed symptoms of PTSD (Exhibit A, pp.508 – 608)

While hospitalized in 2019, Petitioner underwent a pain management consultation for chronic pain during which she reported that prior to her suicide attempt, she suffered from falls, hitting her arm and shoulder. She reported having numbness in the right side of her face, as well as down her right arm, into her first and second fingers. She has had no evaluation by a neurologist or orthopedic specialist. Review of systems indicated that she had right perioral and facial numbness, right arm numbness, intractable back pain and intractable depression. She demonstrated decreased range of motion for neck flexion and extension, side bending and turning of her neck are very painful, numbness in the C6 distribution of her right arm was noted, as was decreased strength with grip and with biceps and triceps function on the right side compared to the left. Reflexes were brisk at the brachial radials and biceps, as well as the triceps bilaterally. Straight leg raise was negative bilaterally and motor function and sensation in the lower extremities was normal. Previous CT of Petitioner's neck revealed a herniated disc at C5 – C6 on the right side. She was diagnosed with cervical radiculopathy. (Exhibit A pp.564 – 569)

Petitioner was again admitted to the Emergency Department of on 2019 until , 2019 with suicidal ideations, fibromyalgia, depression, anxiety, and PTSD. Upon arrival by EMS, she was minimally responsive and had previously given suicidal remarks to her significant other. It was noted that she had a laceration to her right chest. She was found with a left frontal lesion upon CT of the head. A recommendation for inpatient psychiatric stabilization recommended after a medical clearance. Petitioner reported being newly diagnosed with multiple sclerosis and indicated that she did not intentionally hurt herself prior to her admission. She referenced having had a seizure, calling police and then having been dragged by police. Upon evaluation, Petitioner's prognosis was noted to be guarded. In 2019, while Petitioner was admitted for treatment at McLaren Port Huron Hospital, she underwent MRI testing of the brain, which showed multiple foci of abnormal signal in the para ventricular white matter bilaterally. The appearance is suggestive of demyelinating disease. There was a 2.7 x 2.4 cm lesion in the white matter of the left frontal lobe demonstrating incomplete peripheral ringlike enhancement. With the appearance of other white matter lesions, the appearance of this is most suggestive of a tumefactive demyelinating, multiple sclerosis. Petitioner underwent lumbar puncture and parenteral steroids for her multiple sclerosis. She was transferred to the psychiatric unit (Exhibit A, pp. 437 – 497).

Petitioner underwent psychiatric consultation and evaluation for risk of self-harm on 2019. Nursing staff on the medical floor noted that Petitioner continued to have a lot of ups and downs in her mood. She can get very distressed and can be quite intense in her interactions with staff. She talked about feeling isolated and depressed and noted that there was an incident where she believed the nurse hit her in the jaw, but really the nurse was trying to take a pill from Petitioner's mouth that was a medication

that was not administered to her at the time. Petitioner reported that she did not want to be transferred to the psychiatric unit. Mental status examination showed that Petitioner was restless, her thoughts were disorganized, her affect was intense, she was anxious and tearful, her mood was down and it was difficult to determine if she had a thought disorder. The doctor noted that a diagnosis of depressive disorder was appropriate. Records indicate that Petitioner was previously admitted to the mental health unit in ██████ 2019 for a suicide attempt. It was determined that in ████ 2019, she met the criteria for inpatient psychiatric admission due to her alleged suicide attempt, impulsivity and poor judgment, insight and lability. She was not able to admit to the current suicide attempt and was evasive and guarded with information which puts her at a higher risk, especially due to her impulsivity. The recommendation was that a one-to-one sitter monitor Petitioner for her safety and that she be unauthorized to leave against medical advice, possibly requiring a need for a petition and certification if she attempts to leave. Petitioner was discharged from her inpatient psychiatric treatment on ██████, 2019 and was to follow-up through ██████████████████████ (Exhibit A, pp. 421-436)

Records from Petitioner's treatment at ██████████████ were presented and reviewed. On ████████ 2019, Petitioner was evaluated for injury to her left knee following fall. She also presented for follow-up after her admission to the hospital from ██████ through ██████ 2019. Hospital notes indicated that she was petitioned by law enforcement to be admitted due to suicidal ideations, however Petitioner denied that she was suicidal. Petitioner reported that she was extremely upset which caused a fight with the police officers who were very rough with her and dragged her across the ground resulting in a cut to her right chest. It was noted that hospital documentation indicated Petitioner cut herself across the right side of her chest. She denied any suicidal or homicidal thoughts at the time upon examination of the left knee, there was tenderness to palpation along the lateral portion of the knee with significant bruising in the superior lateral portion of the knee with a one plus effusion. On █████, 2019, Petitioner presented to the office following an assault reporting that her boyfriend's ex-girlfriend came in and started beating her up. She reported that the assaulter stepped on her right hand with a high heel which resulted in significant pain and an inability to fully move the third and fourth digits as they were numb and tingly. She also indicated she had a recent Achilles tendon repair apparently from shutting the screen door on her leg as well as continued pain in her shoulder that is being evaluated by orthopedic. Inspection of the right hand revealed a small superficial laceration over the third and fourth MCP joint consistent with a high heel, her hand is diffusely swollen and tender to palpation throughout with bruising. Decreased range of motion of her fingers was also noted. Notes indicate that on █████ 2019, Petitioner presented for evaluation following an emergency room visit the day before due to injury of her right foot and laceration to left knee. On █████ 2019 Petitioner presented for reevaluation of right shoulder pain indicating she was involved in an altercation on █████ during which she was knocked to the ground in her right shoulder was pinned underneath her. She reported that she now has shooting pain down her shoulder and into her lower arm, reported feeling muscle spasms along the exterior shoulder and that she is in

excruciating pain. Tenderness to palpation along the anterior lateral portion of the upper right shoulder was noted upon physical examination. Petitioner was initially evaluated for this right pain on ■■■■, 2019, and during this appointment reported falling three weeks ago in the shower and continuously falling since then. Throughout the examination, Petitioner reported headaches and head injury, asthma, left hand pain, swelling, bruising, decreased range of motion and right shoulder pain. She reported history of assault, depression, anxiety and other psychiatric disorders as well as reporting tingling, numbness, and burning sensations. Examination of the right upper arm and shoulder showed pain with abduction, and with internal/external rotation. Pain was also noted over the coracoid process and AC joint, as well as along the upper trapezius on the right and in the rhomboid area with palpation. Petitioner was to schedule an appointment with an orthopedic specialist for a consultation and further evaluation. (Exhibit A, pp. 174-332)

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 1.02 (Major dysfunction of a joint(s) (due to any cause)), 11.09 (Multiple sclerosis), 11.18 (Traumatic brain injury), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.08 (personality and impulse control disorders), Somatic symptom and related disorders), 12.11(Neurodevelopmental disorders), and 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, 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). 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), to which 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 conditions. Petitioner testified that she was diagnosed with multiple sclerosis (MS) in ██████ 2019 which has attacked her bladder and results in jerking/tremors in her legs, arms, and hands. She reported that she wets her pants daily because she is unable to get to the bathroom in time and that she frequently falls and loses her balance due to her MS. She also testified that at eight years old she suffered a closed head injury and was later involved in a motor vehicle accident that has resulted in nerve pain as well as fibromyalgia in her back, legs, and arms. Petitioner reported that she shakes constantly. Petitioner testified that she is able to walk less than half mile or about 10 minutes before needing to stop and rest. She can sit and stand for only five minutes and reported that she is able to lift a gallon of milk. Petitioner reported that she is able to bend and squat but that she has difficulty gripping and grasping items with her hands as she continuously drops things and they fall out of her hands. Petitioner testified that she is able to bathe herself and care for her own personal hygiene, however, household chores take her much longer to complete, sometimes up to a full day to wash dishes.

Petitioner testified that she has suffered from PTSD since the age of 16 and that she often has flashbacks and paranoia due to her past when faced with trigger points. She reported that she attends psychiatry appointments and medication management monthly and sees a counselor weekly. Petitioner testified that she suffers from anxiety attacks that include symptoms of shortness of breath, seeing stars in her eyes, and that they can last up to 10 minutes multiple times a day. She reported that her mental impairments affect her ability to concentrate and that with medications, she is able to focus for only 15 minutes. She reported having difficulty with her memory for which she has six calendars at home for reminders. She reported that she suffers from crying spells due to her depression that can last anywhere from a few minutes to longer hours and that she has thoughts of hurting herself but not other people. Petitioner reported that she has made various attempts to hurt herself, the last of which occurred in ██████████ 2019. She indicated that she snaps a tie on her wrist when she wants to hurt

herself. Her social interaction is nonexistent, indicating that she avoids people in order to avoid her anxiety and trigger points. Petitioner reported that her medications have side effects which include drowsiness. It was established that Petitioner had three inpatient psychiatric hospitalizations and at least two suicide attempts in 2019. The Department representative present for the hearing testified that she observed Petitioner looking very drowsy throughout the hearing and witnessed Petitioner's hand shaking and body tremors. It was also noted that throughout the hearing, Petitioner was very slow and had difficulties in her responses to questions asked by the undersigned ALJ.

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 her symptoms. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, some of which are referenced above 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 light work as defined by 20 CFR 416.967(b). Based on the medical records presented documenting her severe mental impairments resulting in inpatient psychiatric treatment on three occasions, PTSD symptoms, and suicidal behaviors among others, Petitioner has moderate to marked limitations in her ability to understand, remember, or apply information; moderate to marked limitations in her ability to interact with others; moderate to marked limitations in her ability in her ability to concentrate, persist, or maintain pace and moderate to marked limitations in her ability to adapt or manage oneself. Petitioner's nonexertional RFC is considered at both Steps 4 and 5.

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 employment as a waitress, a cook, and a grocery store deli counter clerk. Upon review, Petitioner's

prior employment is categorized as requiring light exertion. Although based on the RFC analysis above, Petitioner's exertional RFC limits her to light work activities and thus she is not precluded from performing past relevant work due to the exertional requirement of her prior employment, Petitioner has additional nonexertional limitations that would prevent her from being able to perform past relevant work. Therefore, she cannot be found disabled, or not disabled at Step 4 and the assessment continues to Step 5.

Step 5

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

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

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

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

In this case, Petitioner was 35 years old at the time of application and 36 years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She is a high school graduate who has unskilled work history that is nontransferable. 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. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as discussed above, Petitioner has moderate to marked limitations in her ability to understand, remember, or apply information; moderate to marked limitations in her ability to interact with others; moderate to marked limitations in her ability in her ability to concentrate, persist, or maintain pace and moderate to marked limitations in her ability to adapt or manage oneself. 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 nonexertional/mental 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

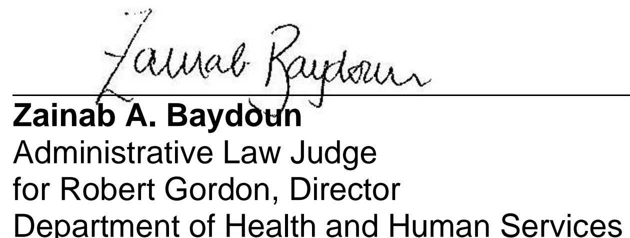
Accordingly, the hearing request with respect to the FIP is **DISMISSED** and the Department's SDA determination is **REVERSED.**

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 [redacted], 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; and

3. Review Petitioner's continued eligibility in [redacted] 2020.



ZB/tm

Zainab A. Baydoun
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	Holly DeGroat 515 South Sandusky Sandusky, MI 48471
Petitioner	[redacted]

cc: FIP: B. Sanborn; M. Schoch
SDA: L. Karadsheh
AP Specialist (St. Clair-2)