STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: May 9, 2017
MAHS Docket No.: 17-001921
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; and 45 CFR 205.10. After due notice, a telephone hearing was held on March 9, 2017, from Detroit, Michigan. Petitioner appeared and represented herself. Her friend, [redacted], testified as a witness on Petitioner's behalf. The Department of Health and Human Services (Department) was represented by Karen Willet, Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner's medical documents from [redacted] and a DHS-4D, psychiatric/psychological evaluation, and DHS-49E, mental residual functional capacity assessment, completed and signed by Petitioner's psychiatrist was received and marked into evidence as Exhibit C. The record closed on April 10, 2017, and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On [redacted], 2016, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On January 3, 2017, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 29-35, 1-28).

3. On January 9, 2017, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On [redacted] 2017, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to back pain, arthritis of the knuckles and knees, chronic migraines, and anxiety and other mental health disorders.

6. On the date of the hearing, Petitioner was 49 years old with a [redacted] 1967 birth date; she is 5'7" in height and weighs about 167 pounds.

7. Petitioner received a GED.

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

9. Petitioner has an employment history of work as an overnight stockperson and a certified nurse assistant.

10. Petitioner has a pending disability claim with the Social Security Administration (Exhibit B).

CONCLUSIONS OF LAW

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

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity

by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

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

Step One

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

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

Step Two

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

lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The medical evidence presented at the hearing, and in response to the interim order, was reviewed and is summarized below.

From [redacted], 2014 to [redacted] 2014, Petitioner was hospitalized for suicide attempt by carbon monoxide poisoning. At discharge, she was diagnosed with bipolar I disorder, not otherwise specified; cannabis abuse; attention deficit hyperactivity disorder, combined type; and cluster B. She was discharged on [redacted] 2014 and transferred to [redacted] for inpatient treatment. (Exhibit A, pp., 73-94, 121-171, 176-206, 268.)

In [redacted] 2016 office notes by the physician's assistant at the general practice Petitioner frequented, Petitioner reported having participated in counseling after the hospitalization for about 6 months but stopping because of mounting medical costs. She reported a worsening of her mental condition and an inability to work since December 28, 2015 due to emotional instability. The physician's assistant noted that Petitioner cried throughout her visit. She was diagnosed with bipolar disorder, in partial remission, depression and anxiety, and ADD (attention deficit disorder), and cervicogenic headaches. She was referred to physical therapy for the headaches and to psychiatry for the mental issues. (Exhibit A, p. 265-268). At the [redacted] 2016 office visit, Petitioner reported improved condition on prescribed Cymbalta with continued cervicogenic headaches but an inability to engage in physical therapy due to cost. She denied suicidal thoughts. She was released for work with no restrictions. (Exhibit A, pp. 261-263.) At the [redacted], 2016 visit, Petitioner reported lower right sided back pain and neck pain for several years (Exhibit A, pp. 258-260). At the [redacted], 2016 visit she reported continued neck pain with headaches and radiation to the left upper arm and missing work occasionally because of her neck and back pain (Exhibit A, pp. 246-249). On [redacted], 2016, Petitioner began physical therapy for her neck, back and shoulder pain (Exhibit A, pp. 235-239, 241-243). On [redacted], 2016, she reported being unable to work due to neck pain, headaches, low back pain, and bowel problems and bleeding. (Exhibit A, pp. 230-233.) At the [redacted], 2016 appointment, she reported

that, although she continued to attend physical therapy, her headaches and neck pain and radiation down her left arm were worse after her therapy sessions. She was referred to a gastroenterologist for her abdominal pain. (Exhibit A, pp. 225-228). At the [redacted], 2016 appointment, she reported that her employer terminated her employment and that she stopped attending physical therapy because it was making her condition worse (Exhibit A, pp. 221-223).

On [redacted] 2013, Petitioner went to the emergency department complaining of headaches with photo and phonophobic sensitivity and nausea. She was diagnosed with acute exacerbation of chronic recurrent migraine cephalalgia. (Exhibit A, pp. 207-216.)

A [redacted], 2016 cervical spine x-ray showed no fracture or subluxation and no significant degenerative changes (Exhibit A, p. 251).

On [redacted] 2016, Petitioner had a consultative examination with a neurologist to address her headaches. She reported headaches occurred at least three to four times a week and were currently 75-80% controlled. She also complained of tinnitus. The doctor noted that a 2014 head CT was normal. Petitioner had been treated with physical therapy and tricep muscle relaxants for muscle spasms with some efficacy, and the doctor recommended Topomax to prevent headaches that did not correlate with her cervical neck pain. (Exhibit A, pp. 328-331.)

On [redacted], 2016, Petitioner had a consultative examination with a gastroenterologist concerning blood in the stool, constipation, and diffuse abdominal pain. The doctor recommended a CT scan and colonoscopy. (Exhibit A, pp. 279-290.) The colonoscopy showed evidence of internal hemorrhoids but no evidence of active inflammation or bleed and was otherwise unremarkable (Exhibit A, pp. 277-278).

In [redacted] 2016, Petitioner began psychiatric treatment with a LMSW (licensed master social worker). She was diagnosed with generalized anxiety disorder and assigned a global assessment of functioning (GAF) score of 55. Petitioner reported four suicide attempts, the last two years earlier. She denied current suicidal or homicidal ideation but stated that she felt that her Seroquel made her feel suicidal and, while she had not attempted suicide at that time, “it’s in [her].” She was “hang[ing] on to anger” and having a hard time letting things go. She also reported that medication she received from the neurologist for her chronic migraines “made [her] flip.” She stated that she had high anxiety, isolated herself, and suffered from panic attacks a couple times a day. (Exhibit A, pp. 293-311.)

On [redacted] 2017, Petitioner’s psychiatrist, who began treating her [redacted] 2017, completed a psychiatric evaluation diagnosing her with major depression, recurrent, severe, without psychosis; PTSD (post-traumatic stress disorder) and ADHD (attention deficit hyperactivity disorder) and assigned her with a GAF score of 45. Petitioner reported chronic symptoms of depressed mood, low self-esteem, low motivation, fatigue, anxiety/episodes of panic, insomnia, confining herself to her home, having little

motivation or interest in social interactions and no friendships. The psychiatrist noted that Petitioner was alert and oriented, cooperative, visibly anxious, and uncomfortable and had appropriate judgment, linear thought process, poor self-esteem and intact impulse control. (Exhibit C.)

On [redacted], 2017, Petitioner's psychiatrist also completed a mental residual functional capacity assessment, DHS-49-E, regarding Petitioner's mental impairments and how they affected her activities. The psychiatrist concluded that Petitioner had no, or no significant, limitations regarding her ability to understand and remember one or two-step instructions; carry out simple one or two step instructions; and be aware of normal hazards and take appropriate precautions. The psychiatrist concluded that Petitioner had moderate limitations regarding her ability to remember locations and work-like procedures; understand and remember detailed instructions; carry out detailed instructions; sustain an ordinary routine without supervision; make simple work-related decision; ask simple questions or request assistance; get along with co-workers or peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness; and set realistic goals or make plans independently of others. The psychiatrist concluded that Petitioner had marked limitations regarding her ability to maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; work in coordination with or proximity of others without being distracted by them; complete a normal workday and worksheet without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; interact appropriately with the general public; accept instructions and respond appropriately to criticisms from supervisors; respond appropriately to change in the work setting; and travel in unfamiliar places or use public transportation. (Exhibit C.)

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), 1.04 (disorders of the spine), 12.06 (anxiety and obsessive-compulsive 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. 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 nonexertional limitations due to her medical condition. Petitioner testified that she suffered from low back pain, arthritis that affected her hands and knees, chronic migraines, and mental health issues. She stated she walked using a back brace and could walk not more than 5 minutes. She could sit about an hour, although she would have to shift around in the seat. She could lift about 10 pounds. She could not stand long and had difficulty using both hands. She lived alone and was able to bathe and dress herself. She limited the chores she did. Her friend helped her with shopping because she was embarrassed of her condition. She limited her driving because of her anxiety. She did not go out much. She walked around her yard. She complained of anxiety that limited her ability to perform her job.

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. A medically determinable impairment is based on objective medical evidence (medically acceptable clinical and laboratory diagnostic techniques) from an acceptable medical source. 20 CFR 416.921.

Petitioner's medical records show that she reported to her primary care physician in May 2016 that she had back and neck pain for several years. At a [redacted], 2016 visit,

she reported continued neck pain with headaches and radiation to the left upper arm and back pain. A [redacted] 2016 cervical spine x-ray showed no fracture or subluxation and no significant degenerative changes. Therefore, there is insufficient evidence of a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms of back and neck pain. There was also no medical evidence of arthritis of the knees or knuckles, as alleged by Petitioner.

The neurologist who examined Petitioner on [redacted] 2016 noted that a 2014 head CT was normal. The record shows ongoing treatment for chronic headaches, and in [redacted] 2016, Petitioner went to the emergency department and was diagnosed with acute exacerbation of chronic recurrent migraine cephalalgia. In her August 9, 2016 consultative exam with a neurologist, Petitioner reported that her headaches occurred three to four times a week and were 75-80% controlled. The doctor found that Petitioner's physical therapy and tricep muscle relaxants had provided some efficacy and recommended other medication to prevent headaches unrelated to neck pain. This evidence supports Petitioner's complaints of headaches. Petitioner has mental health diagnosis including major depression, PTSD, ADHD and generalized anxiety disorder, supporting her mental health symptoms of anxiety and depression. She had limited treatment in [redacted] 2016 and, after moving, started treatment with a new provider in [redacted] 2017. Petitioner had been treated by this psychiatrist for less than three months at the time he completed the [redacted], 2017 mental residual functional capacity assessment. Based on the psychiatrist's responses, Petitioner had mild limitations on her ability to understand, remember, or apply information, particularly in a simple, unskilled setting; moderate limitations on her ability to interact with others; moderate to marked limitations in her ability to concentrate, persist, or maintain pace; and moderate limitations on her ability to adapt or manage oneself. Petitioner also has mild nonexertional limitations to her concentration due to headaches.

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 work as an overnight stockperson and a certified nurse assistant. Petitioner's past relevant work,

which required substantial lifting, is properly categorized as requiring heavy to very heavy physical exertion.

Based on the RFC analysis above, because there was no medically determinable impairment that could reasonably be expected to produce her alleged symptoms of back and neck pain, Petitioner does not have any limitations to her exertional RFC. Thus, she is not precluded from performing her past employment due the physical requirements of that work. Petitioner also has a nonexertional RFC that imposes limitations to her ability to engage in basic work activities due to headaches and due to her mental condition. However, it is found that Petitioner's limitations do not prevent her engagement in simple, unskilled labor and, accordingly, she is capable of her past employment as an overnight stockperson. Because Petitioner is able to perform past relevant work, she is not disabled at Step 4 and the assessment ends.

DECISION AND ORDER

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

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

ACE/tlf

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) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

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

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

Via Email:

MDHHS-Muskegon-Hearing@michigan.gov
BSC4 Hearing Decisions
B. Cabanaw
D. Shaw
MAHS

Petitioner –
Via First-Class Mail:

[redacted]