STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

ORLENE HAWKS
DIRECTOR

TAMRA BUTTERFIELD
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Date Mailed: February 1, 2019
MAHS Docket No.: 18-009950
Agency No.: 101356233
Petitioner: Tamra Butterfield

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

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 November 29, 2018, from Detroit, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Amy Breakey, Family Independence Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. **The requested documents were NOT received.** The record closed on January 2, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

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

1. On April 1, 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On September 6, 2018, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 362).

3. On September 13, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On September 24, 2018, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged mental disabling impairments due to Bi-polar disorder, depression and anxiety. The Petitioner alleged physical disabling impairments due to arthritis, hypercholesteremia and severe deviated septum. The Petitioner also alleged Gastroenteritis. The Petitioner also alleged chronic pain in her back, neck, and right shoulder and sacroiliac joint.

6. On the date of the hearing, Petitioner was 51 years old with a January 19, 1967, birth date; she is 5' 2" in height and weighs about 191 pounds.

7. Petitioner is a high school graduate.

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

9. Petitioner has an employment history of work as waitress/server, cashier at a convenience store, and in-home care giver.

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

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, was reviewed and is summarized below.

The Petitioner alleges mental disabling impairment due to history of bipolar disorder and recent episode of severe depression. The Petitioner has treated with a therapist for several months who composed a letter dated November 28, 2018, which confirmed that Petitioner appears to be dealing with long-term grief and loss during the past year impacting her ability to work, sleep and personal self-care. The therapist noted that the plan was to stabilize the Petitioner's mood and develop better coping skills to address trauma, stress and self-care needs. The therapist's letter did not indicate the start of treatment, the duration of treatment or duration of symptoms continuing. The letter does not address prognosis or the impacts of the Petitioner's depression on her ability to work. (Petitioner Exhibit 1.)

Petitioner's employment records submitted indicate that she began a doctor-excused leave on April 9, 2018, which was extended through May 9, 2018. The Notes indicate cause of absence was due to "Illness". The last note was written on May 24, 2018, with a return to work on June 24, 2018, without restrictions. (Petitioner Exhibit 1, p. 3.)

In November 2018, the Petitioner was seen in the ER with complaints of abdominal pain and was diagnosed with gastroenteritis (viral). Petitioner was not admitted to the hospital.

At the time of her interview with the Department, Petitioner reported appetite loss and sleep problems.

The Petitioner was seen in the ER on February 13, 2017, for left chest pain and was discharged after testing including ECG, 2 x-rays of chest negative for effusion, infiltrate or pneumothorax, Normal EKG, and no change to or complications with her gastric mesh surgery. Patient was discharged home.

The Petitioner had a CT of the pelvis on July 21, 2017, and February 13, 2017. The July test showed postsurgical changes consistent with Roux-en-y surgery, (gastric bypass) with no bowel obstructions, cystic changes left kidney, post cholecystectomy changes with minor ductal dilation, no obstructive uropathy, and ventral wall hernia repair.

The Petitioner participated in an Independent Medical Examination on August 11, 2018, arranged by the Department. The examiner raised questions as to whether the Petitioner had limited range of motion in knees or ankles being unable to determine if the test was accurate or result due to lack of effort by Petitioner. The examiner concluded the following: on her examination "today I am unable to say whether this examination is consistent with severe pain and dysfunction or if it is due to the patient's poor effort. In watching her ambulate and move about with the medical assistant and within our waiting area as well as the clinical examination, I do believe that this patient is able to sit and stand for at least limited to moderate periods of time. She can bend and stoop infrequently. She can carry, push, or pull. She can button close, tie shoes, dress and undress, dial the phone, open the door, make a fist, pick up a coin and pencil and write. She refuses to squat down and come back up for me. With sacroiliac joint dysfunction, it is possible that this is possible for the patient. She is able to get on and off the exam table and I do believe that she can climb a few stairs to get in and out of the building."

The Petitioner was examined for her psychiatric claims by independent examiner July 25, 2018. The Petitioner reported disability due to panic attacks, anxiety, bipolar and depression. The panic attacks began in around January 2018 ultimately occurring almost daily triggered by any sense of stress. She also became very depressed with social avoidance, low energy, fatigue, loss of interest, poor concentration and initial and middle insomnia. She recently started psychotherapy at North Country Community

Mental Health. At the time of the exam, the Petitioner reported she was homeless with no source of income. The mental status noted she was pleasant and cooperative, spoke at a normal rate and volume with interruptions due to periods of crying. Thoughts were logical, coherent and goal-directed mood was depressed; she was tearful throughout most of the exam and very limited range of affect, not smiling and laughing; the Petitioner was found to be able to handle disability funds. The medical Source Statement stated on the whole claimant appears clear in describing symptoms and prop and in performance of mental status tests. The claimant's ability to understand, remember and apply information is mildly impaired by poor concentration. The Claimant's ability to work persistently at an acceptable pace and to attend work throughout a full day is severely impaired by depressed mood, low energy, high anxiety and panic attacks. The Claimant's ability to interact with others appropriate in job settings is moderately impaired she would probably have displays of tearfulness and high anxiety that would be distracting for coworkers and the public. The Claimant's ability to adapt to work changes, utilize public transportation, travel to unfamiliar places and set realistic goals is adequate. Claimant's prognosis for improvement is good. Optimizing her psychiatric medication regimen and adding some psychotherapy could well lead to significant improvement for her. The Diagnosis was Bipolar II mood disorder, currently depressed moderate.

The medical records did not contain medical tests or treatment records to demonstrate the degree or ongoing nature of low back pain and neck pain.

The Petitioner was seen by AHC Community Health Centers requesting a clearer letter for FMLA for her work and needs something more in her letter. The assessment was major depressive disorder, single episode, severe without psychotic features, involutional melancholia, moderate. Plan was to follow up in one month. Also, evaluation by CMH candidate for residential care. The Petitioner was also seen on May 8, 2018, at which time the Petitioner was assessed with major depressive disorder, single episode.

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 12.04 Depressive, bipolar and related disorders; 12.06 Anxiety and obsessive -compulsive disorders were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). *This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3).* The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, non-exertional, 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 non-exertional 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 (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) 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 walk one block and sit at least an hour and then must move around, she could stand 30 minutes to one hour but would have to put her foot up. Petitioner could not perform a squat and could bend forward and sideways at the waist. She could shower and dress herself and tie her shoes. The Petitioner said she had difficulty with her right arm and shoulder and then her lets and feet were fine. She could carry 7 pounds with her left hand and said she was unsure she could use a pen. Petitioner testified that she had pain level of 7 due to chronic pain in her back and neck. Petitioner also testified at the hearing to having pain in her right knee and hip due to arthritis. She also testified to limping but did not use a cane. At the hearing, Petitioner testified that she is not prescribed any pain medications for her pain. With respect to her mental limitations, the Petitioner had anxiety with shakes and heart racing making it hard to talk and that she has crying spells daily. She further described symptoms of being distracted and side tracked due to her anxiety and has difficulty sleeping. She is able to cook simple meals in the microwave and keep her medical appointments and is able to straighten up where she is living during the day and is able

to do laundry, and her roommate shops for her. Also considered was the independent medical exam which indicated that Petitioner can button clothes, tie shoes, dress and undress, dial a phone, open a door, make a fist and pick up a coin and pencil and write. She was also capable of climbing a few stairs necessary to get in and out of the building. Petitioner was able to get on and off the exam table and also no range of motion in any of her joints was noted as other than normal as well as her cervical, and lumbar spines and knees, her hips were mildly less than normal for range of motion. Most importantly the examiner notes that she can sit and stand for at least limited to moderate periods of time can bend stoop infrequently and can carry, push, or pull.

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 limitations on her mental ability to perform basic work activities. However, the independent examiner who performed the mental status exam noted that Petitioner's ability to work persistently at an acceptable pace and to attend work throughout a full day is severely impaired by depressed mood, low energy, high anxiety and panic attacks.

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 work as a waitress, as a cashier at a convenience store, and as a caregiver for adults, as a nurse's assistant. Petitioner's work as a waitress required her to be on her feet all day, interact with people and carry trays weighing 5 pounds, which required standing 4 hours

and lifting up to 5 pounds regularly, required light physical exertion due to the walking and standing. Petitioner's work as a cashier at a convenience store also required that she stand for 4 hours and required interaction with customers. This work also is considered to be light physical exertion due to the standing and walking requirements. The Petitioner work as a caregiver, a nurse's assistant required transferring, bathing feeding patients as well as grocery shopping. As such, this work could be considered medium-to-heavy work due to having to transfer patients.

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 moderate limitations in her mental capacity to perform basic work activities.

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 non-exertional 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 51 years old at the time of application and 51 years old at the time of hearing, and thus, considered to be closely approaching advanced age (age 50-54) for purposes of Appendix 2. She is a high school graduate with a history of work experience as a waitress, caregiver and convenience store cashier. 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.

Based solely on her exertional RFC, the Medical-Vocational Guidelines, 201.13, result in a finding that Petitioner is not disabled.

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 limitations in her social functioning; and severe limitations only persistence or pace limitations and her ability is concentrated, is mildly impaired. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is **not** disabled at Step 5.

DECISION AND ORDER

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

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

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 Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

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

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

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

DHHS

Amy Assante
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