[redacted]

Date Mailed: May 31, 2019
MOAHR Docket No.: 19-001979
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton

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 April 1, 2019 from Detroit, Michigan. Petitioner appeared on behalf of herself. Participants on behalf of the Department of Human Services (Department) included Loren Williams, Assistance Payments Supervisor.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Records from [redacted], [redacted], [redacted] and [redacted]. were received and marked into evidence as Exhibit 1. The record closed on May 1, 2019, 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], 2018, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On February 6, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 50-56).

3. On February 15, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability (Exhibit A, pp. 6-7).

4. On February 25, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, p. 2).

5. Petitioner alleged disabling impairment due to chronic neck pain, bone spurs, migraine headaches, arthritis, left hip pain, carpal tunnel syndrome, depression, anxiety, and PTSD.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], 1967 birth date; she is 5'3" in height and weighs about 187 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 a caregiver, maintenance worker and lift operator.

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

CONCLUSIONS OF LAW

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

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (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 individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen, 880 F2d 860, 862-863 (CA 6, 1988), citing Farris v Sec of Health and Human Services, 773 F2d 85, 90 n.1 (CA 6, 1985).* A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. *Id.; SSR 96-3p.*

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

On May 9, 2018, Petitioner was seen at [redacted] for an x-ray of her abdomen. There was considerable obscuration of renal beds by bile content. Note definite evidence of urinary tract calculus. No evidence of bowel dilatation or obstruction. There were right upper quadrant surgical clips. Scoliosis was noted. Soft tissue calcification superior to the left greater trochanter could be related to tendinitis or bursitis. (Exhibit A, pp. 112-113). Petitioner was also seen for complaints of back pain, rectal bleeding, and depression. The assessment provided the following diagnosis: anxiety and depression; long-term (current) use of opiate analgesic; chronic neck pain; environmental allergies; other migraine without status migrainosus, intractable; flank pain; screening for breast cancer; screening for colon cancer. (Exhibit A, pp. 118-121).

On July 16, 2018, Petitioner was seen at [redacted] for a CT of the abdomen and pelvis with contrast. Relating to the lungs, there was no focal infiltrate or mass. Relating to the liver, there was a small cyst in the left lobe of the liver. There was

no solid hepatic mass. There was mild intrahepatic biliary dilatation. Relating to the gallbladder, it had been resected. There was mild dilatation of the intrahepatic bile ducts and the CBD which measured approximately 10mm. The spleen was normal in size. (Exhibit A, pp. 113-115).

On July 30, 2018, Petitioner was seen at [redacted] for urinary leakage. Petitioner voids frequently with urgency and incontinence. She also leaks small amounts of urine when coughing, sneezing, and laughing. Petitioner complained of pain in her lower right quadrant. Petitioner also indicated that she had a vaginal yeast infection at her last office visit and further stated that she gets them all the time. Petitioner was found to also have incomplete bladder emptying with PVR of 280 ml. (Exhibit A, pp. 94-96).

On August 1, 2018, Petitioner was seen at [redacted] for an EMG. Petitioner was taught pelvic floor strengthening exercises and given a level to begin with. Petitioner was then taught suppression techniques. (Exhibit A, pp. 97-99).

On August 8, 2018, Petitioner was seen at [redacted] for a follow-up visit regarding her urinary frequency. It was noted that Petitioner was working with urology to strengthen muscles to better urinate. Petitioner may have to self cath. There is no improvement. Petitioner continues to have some pain. It was noted that if there was no significant improvement the plan was upper endoscopy to general surgery. (Exhibit A, pp. 127-128).

On August 10, 2018, Petitioner was seen at [redacted] relating to her diagnoses of urinary frequency, urinary urgency, and pelvic muscle wasting. Avoiding diary was discussed with Petitioner. Urge suppression techniques were also discussed. (Exhibit A, pp. 99-103).

On August 13, 2018, Petitioner was seen at [redacted] with concerns of urinary frequency and urgency. Daytime frequency was every two hours. The report noted that Petitioner also has stressed incontinence and underwent a sling procedure in 2006. Petitioner was wearing two pads per day and sometimes noticed a brown color in her pad. Petitioner indicated she has rectal bleeding and had an upcoming appointment to address this complaint. The assessment indicated urinary frequency, urinary urgency, and mixed incontinence. (Exhibit A, pp. 92-93).

On September 19, 2018, Petitioner was seen at [redacted] with the chief complaint of depression. Petitioner indicated that the current episode started more than one month prior to the visit. Petitioner was also seen for hip pain that began one week prior to the visit. Petitioner reported the hip pain as chronic. The following diagnoses were provided: anxiety and depression; hip pain, migraine; and chronic neck pain. (Exhibit A, pp. 139-134).

On September 27, 2018, Petitioner was seen at [redacted]. X-rays of the left hip and pelvis were taken. The findings included no evidence of fracture,

dislocation, or other acute bony abnormality. The hip joint spaces were well maintained. (Exhibit A, pp. 117-118).

On October 3, 2018, Petitioner was seen at [redacted] for a colonoscopy. Internal hemorrhoids were found during retroflexion enduring digital exam. The hemorrhoids were Grade 1. A 3 mm polyp was found in the transverse colon. The polyp was removed with jumbo forceps. Resection and retrieval were complete. The right colon was moderately tortuous. The terminal ileum was normal. (Exhibit A, pp. 109-111).

On February 4, 2019, Petitioner was seen by [redacted], Ph.D, for a psychiatric/psychological examination. Petitioner cried throughout the examination. Petitioner's motor activity was found to be within normal limits. Dr. Lem indicated that Petitioner appeared poorly motivated and lacked insight. Petitioner denied any suicidal ideation but was found to clearly struggle with depressive symptoms and passive suicidal thinking. There were no homicidal ideations noted and no psychotic symptoms noted. It should be noted that the remainder of the report appears to have been omitted from the submission as a heading for additional information appears at the bottom of page 11 of Exhibit 1 but the report abruptly ends with no signature page. As such, it is unclear what was contained in the final conclusions.

On February 16, 2019, Petitioner was seen at [redacted], PC for a consultative examination. Petitioner's chief complaints included left hip pain, lower back pain, cervical spine pain, and migraines. The conclusions included that no sensory changes were noted; Petitioner's grip strength was well maintained. Petitioner's digital dexterity was intact. Petitioner was able to pick up a coin; button clothing and open doors with either hand. The report indicated that there did not appear to be nerve root impingement. Petitioner was noted to walk normally and did not have difficulty with orthopedic maneuvers. Petitioner was able to ambulate without an assistive device. There conclusions further indicated that by Petitioner's report, she may have migraine with aura. There were no findings relative to Petitioner's diverticular disease or depression. (Exhibit 1, pp. 12-15).

On March 7, 2019, Petitioner was seen at [redacted] department for a cervical spine x-ray. The findings included that there was slight reversal of the normal cervical lordosis. Moderate degenerative disc disease was present at C5-6 and C6-7. Small posterior and anterior spurs were present at these levels. Alignment in AP was unremarkable. (Exhibit 1, p. 1).

On April 24, 2019, Petitioner was seen at [redacted] for an MRI of the cervical spine without contrast. The findings were as follows: C2-C3: No significant disc or facet abnormality. No spinal canal stenosis or foraminal stenosis; C3-C4: Mild facet degenerative changes; C4-C5: Mild disc space narrowing with endplate osteophyte. Mild facet degenerative changes with posterior annular bulge and small midline and left central disc protrusion with mild-moderate thecal sac stenosis. C6-C6: Moderate-severe disc space narrowing with endplate osteophyte. Mild thecal sac stenosis. Neural

foramina were present; C6-C7: Moderate-severe disc space narrowing with endplate osteophyte. Mild left foraminal stenosis due to uncinate hypertrophy. Posterior disc osteophyte complex with mild thecal sac stenosis. Right neural foramen was patent. Mild facet degenerative change. C7-T1: Facet degenerative change. No significant thecal sac or foraminal stenosis. The conclusion indicated that there were multilevel cervical spine degenerative changes as outline above. No critical right-sided lesions to account for reported right-sided symptoms and no significant change compared to prior imaging. (Exhibit 1, pp. 4-5).

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); 12.04 (depressive, bipolar and related disorders); and 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, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of

functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3). For the first three functional areas, 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 condition. Petitioner testified that she could dress/undress herself; use the bathroom unassisted; eat by herself; squat; bend at the waist; sit; kneel; and climb stairs. However, Petitioner indicated that she experienced pain while completing chores and using her hands. Petitioner further indicated that she could not stand longer than 10 minutes without experiencing pain. Petitioner testified that she was able to reach in front of her but experienced pain when she attempted to reach over her head. Petitioner stated that she had issues with memory due to stress. Petitioner indicated that she needed to start and stop when completing tasks due to pain and also due to lack of concentration. Petitioner did not note any issues associated with sitting.

The medical evidence presented revealed that Petitioner continues to suffer from urinary frequency/urgency. It appears that this condition causes Petitioner to use the bathroom approximately every two hours. Petitioner complained about migraine headaches and arthritis. However, there was no medical evidence presented to show that Petitioner was being treated for issues relating to migraine headaches or arthritis.

Petitioner complained of left hip pain. The September 2018 x-rays indicated that the hip joint spaces were well maintained. While it is true that the April 2019 MRI indicated that there was moderate-severe disc space narrowing with endplate osteophyte, the conclusion indicated that there were no critical right-sided lesions to account for reported right-sided symptoms and no significant change compared to prior imaging.

The only mental health medical evidence provided was the February 4, 2019 psychiatric/psychological evaluation. It should be noted that the remainder of the report appears to have been omitted from the submission as a heading for additional information appears at the bottom of page 11 of Exhibit 1 but the report abruptly ends with no signature page. As such, it is unclear what was contained in the final conclusions.

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 light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as

Petitioner's testimony, Petitioner has mild limitations on her mental ability to perform basic work activities. 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 a maintenance worker, lift operator and machine operator. Petitioner's work as a lift operator required her to sit in a heated booth and push an emergency stop when needed. Petitioner's work as a lift operator required sedentary physical exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than light work activities. As such, Petitioner is capable of performing past relevant work. Further, Petitioner has mild limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's nonexertional RFC do not prohibit her from performing past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

DECISION AND ORDER

NOT DISABLED: 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.**

JAM/tlf

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

Via Email:

MDHHS-VanBuren-Hearings
BSC3 Hearing Decisions
Policy-FIP-RAP-SDA
MOAHR

Petitioner – Via First-Class Mail:

[redacted]