[redacted]

Date Mailed: June 27, 2019
MOAHR Docket No.: 19-003324
Agency No.: [redacted]
Petitioner: [redacted]

**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 May 29, 2019, from Detroit, Michigan. Petitioner appeared for the hearing and was represented by her Authorized Hearing Representative (AHR) [redacted]. The Department of Health and Human Services (Department) was represented by [redacted], Assistance Payments Supervisor and [redacted], Eligibility Specialist.

## ISSUE

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

## FINDINGS OF FACT

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

1. Petitioner was an ongoing recipient of SDA benefits. In or around June 2016, Petitioner was approved for SDA benefits based on a Disability Determination Service (DDS) finding that at the time, her condition met or equaled a listing under 14.02B (systemic lupus erythematosus). (Exhibit B, pp. 4-12)

2. In June 2018 the Department and DDS initiated a review of Petitioner's continued eligibility for SDA benefits. (Exhibit A, pp. 13-27)

3. On or around August 31, 2018 the DDS found Petitioner not disabled for purposes of continued SDA benefits. DDS determined that Petitioner was capable of performing light work. (Exhibit A, pp.47-71)

4. On March 11, 2019 the Department sent Petitioner a Notice of Case Action advising her that effective April 1, 2019, her SDA benefits would be terminated based on DDS' finding that she is not disabled. (Exhibit A, pp. 37-40)

5. On March 27, 2019 Petitioner requested a hearing disputing the Department's termination of her SDA benefits and the DDS finding that she was not disabled.

6. Petitioner presented a Health Summary, on which she alleged continuing disabling impairments due to 54 physical and mental conditions, some of which included: degenerative disc disease (L1-L5) with spinal stenosis and spondylitis, obstructive sleep apnea (OSA), asthma, history of pulmonary embolism and deep vein thrombosis, rheumatoid arthritis, systemic lupus erythematosus (SLE), cutaneous lupus erythematosus (discoid lupus), Sjogren's syndrome, fibromyalgia, interstitial cystitis (IC), endometriosis, carpal tunnel syndrome (CTS), peripheral neuropathy, major depressive disorder, anxiety, panic disorder, post-traumatic stress disorder (PTSD), bipolar disorder, borderline personality disorder, and obsessive compulsive disorder (OCD). (Exhibit A, p. 41)

7. As of the hearing date, Petitioner was [redacted] years old with a January 11, [redacted] date of birth. She was [redacted] and weighed [redacted] pounds. Petitioner has a high school education and has reported employment history of work as a customer service representative, a sales associate, a pet caretaker and veterinary assistant. Petitioner has not been employed since January 2012. (Exhibit A, pp. 69-70)

8. 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 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.

A disabled person is eligible for SDA. BEM 261 (July 2014), 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 lasting, or expected to last, 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).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5).

In this case, Petitioner has not engaged in SGA at any time since she became eligible for SDA. Therefore, her disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
>
> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
>
> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).
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> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue.

If an exception from the first group of exceptions to medical improvement applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

**Step 5.** If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

**Step 6.** If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

**Step 7.** If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

**Step 8.** Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

**Step One**

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

In the present case, Petitioner alleged continued disability due to 54 physical and mental conditions including degenerative disc disease (L1-L5) with spinal stenosis and spondylitis, obstructive sleep apnea (OSA), asthma, history of pulmonary embolism and deep vein thrombosis, rheumatoid arthritis, systemic lupus erythematosus (SLE), cutaneous lupus erythematosus (discoid lupus), Sjogren's syndrome, fibromyalgia, interstitial cystitis (IC), endometriosis, carpal tunnel syndrome (CTS), peripheral neuropathy, major depressive disorder, anxiety, panic disorder, post-traumatic stress disorder (PTSD), bipolar disorder, borderline personality disorder, and obsessive compulsive disorder (OCD). (Exhibit A, p. 41). The medical evidence presented since the June 2016 DDS decision finding Petitioner disabled was thoroughly reviewed and is briefly summarized below.

Records from Petitioner's 2017 to 2018 visits with her doctor at [redacted] were presented for review and show that she continued to receive treatment for the above referenced medical conditions and that she was prescribed several medications to address her symptoms. Physician notes from July 12, 2017 indicate that Petitioner presented to the clinic for follow-up after a July 2 to July 3 hospitalization, during which she was diagnosed with bilateral multiple small pulmonary embolisms and treated for shortness of breath, lupus positive, fibromyalgia, and anti-phospholipid syndrome. It was noted that Petitioner requires the use of a straight cane and a wheeled walker and is dependent on assistance with household chores and activities of daily living. Physician notes from February 1, 2018 indicated that Petitioner presented with complaints of a staph infection on the back of her neck, sharp shooting pain in her vagina and during urination. Petitioner was receiving treatment for interstitial cystitis and she has two interstimulator pacemakers implanted. Petitioner's BMI was documented to be 58.19. In May 2018, Petitioner reported cough and breathing problems when walking small distances. She reported wheezing and increased shortness of breath, for which she has been using her inhalers daily with minimal improvement. History of lupus, rheumatoid arthritis and fibromyalgia was also noted. Physical examination of Petitioner's mouth/throat showed oral lesions, specifically lupus ulcers on the tongue and upper lip as well oropharyngeal exudate. She had decreased breath sounds, and rhonchi in the left middle field and the left lower field. She was diagnosed with asthma with acute exacerbation. On June 27, 2018, Petitioner presented to the clinic for follow-up after a visit to the emergency department five days prior, during which she was treated for a urinary tract infection after presenting with complaints of increased abdominal pain, dysuria, and nausea. It was noted that Petitioner has underlying interstitial cystitis, fibromyalgia, irritable bowel syndrome, and lupus which may confuse some of the symptoms. Petitioner was treated with antibiotics. On July 24, 2018, Petitioner was examined by her physician, as she had concerns of a

lupus flareup because her face was red and warm, and she has different rashes. She continued to report stomach pain, night sweats, fever of up to 100°F, dizziness, and back pain that has been worsening. After examination, she was diagnosed with acute cystitis without hematuria, rosacea, dysuria, generalized abdominal pain and a urinary tract infection that was diagnosed by urine dipstick. Progress notes from an August 9, 2018, visit show Petitioner reported her fevers continue to come and go, that her face gets very red and warm, and that the symptoms are related to her lupus. She reported continuous chronic pain on a regular basis including low back pain. She also reported that her migraines have continued, and it was noted that she is on suppressive therapy and using Imitrex. The examining physician indicated that he has reiterated on several occasions to Petitioner that her complaints about her worsening health conditions are likely medication side effects and the interactions of them. He recommended that she and her boyfriend look for an inpatient psychiatric facility to try and wean her down off of medications under the direction of a trained staff and then consider intensive CBT and possible ETC therapy. (Exhibit A, pp. 151 – 350, 786-953, 1554-1754, 2365-2550)

Records from Petitioner's July 2, 2017 to July 3, 2017 hospital admission show that she presented to the emergency department with multiple complaints and a noted history of SLE for which she takes an immunosuppressive and warfarin for anticoagulation. Upon physical examination, her paraspinal muscles were tender to palpation bilaterally along the lumbar spine, she had observable shortness of breath, complained of abdominal pain with nausea, vomiting, diarrhea, as well as increased fevers over the past week. Pulmonary CT Angiography Petitioner's chest showed acute nonocclusive pulmonary embolism within the segmental and subsegmental branches of the bilateral lower lobes and there was no evidence of pulmonary infarct or right heart strain. No acute inflammatory process was identified within the visualized abdomen and pelvis on a CT of Petitioner's abdomen and pelvis. (Exhibit A, pp. 2146-2221)

On September 21, 2017, Petitioner presented to the emergency department at [redacted] with complaints of abdominal pain and loose stools, indicating that she is currently being treated for C. diff by her primary care physician, and reported having approximately 20 bowel movements per day with associated nausea. She reported concerns for near syncope and generalized weakness. The examining doctor indicated that upon reassessment, there was no vomiting, no diarrhea, and he concluded that a bowel obstruction, cholecystitis, appendicitis or gastritis were all doubtful based on her symptoms. (Exhibit A, pp. 2344-2363)

On November 21, 2017, Petitioner presented to the emergency department at [redacted] with complaints of abdominal pain, nausea, diarrhea bilateral lower extremity cramping, and intermittent headaches for the past several weeks. Petitioner reported past history of C. diff that has been treated with medications without success and noted that this is an exacerbation of her chronic condition. Petitioner was treated and released and instructed to follow up with her primary care physician and her G.I. specialist. (Exhibit A, pp. 387-411). On June 23, 2018, Petitioner presented to the emergency department due to progressively worsening abdominal pain with nausea, diarrhea, and constipation, shortness of breath, and pain that is sharp and stabbing. Her complex

medical history was identified on the records, as was her prior diagnoses and surgical history. No noted abnormalities were found on a chest x-ray completed and results of a CT scan of Petitioner's abdomen and pelvis showed hepatic steatosis, signs consistent with severe fatty liver disease is mild cecal colonic fluid retention, and a small anterior uterine wall mass, potentially leiomyoma. Petitioner was treated and released to follow up with her primary care physician. (Exhibit A, pp. 630- 661)

Treatment records and clinic notes from Petitioner's 2017 and 2018 visits at [redacted] were presented for review. During her visits, Petitioner reported significant shortness of breath on exertion, cough with thick green sputum production, wheezing, significant fevers with associated chills and night sweats, weakness, fatigue, chest pressure, and difficulty breathing. Notes indicate that a pulmonary function test was completed in October 2016 and showed normal spirometry, no significant post bronchodilator response, and that lung volumes indicated air trapping and hyperinflation. Diffuse capacity was normal. It was noted that her pulmonary function testing is more concerning for restrictive physiology and that her morbid obesity play a role in her symptoms, as does her diagnosis of mild intermittent asthma, and SLE. Records indicate that Petitioner was prescribed various inhalers that were to be used daily and notes show that she required the use of a CPAP machine for sleep apnea. (Exhibit A, pp. 662-752)

Records from [redacted] pain management indicate that Petitioner received a caudal epidural injection due to lower and mid back pain/lumbago, spinal stenosis with no claudication, lumbar radiculopathy, and lumbar spondylolysis on February 27, 2018. In January 2018 upon examination, the curvature of her spine was flattened, and she had limited range of motion to her lumbar spine. On March 28, 2018, Petitioner reported to her physician that the epidural injection made her pain worse. Her gait was observed to be abnormal and her mood and affect anxious with pressured speech. Additional diagnosis of lumbar radiculopathy and SLE pain were noted and it was indicated that she would not be undergoing any further injections. Records indicate that she was prescribed Percocet and Cymbalta. (Exhibit A, pp.753 – 785, 1962-1979)

Progress Notes from Petitioner's December 5, 2017 visit at [redacted] with Dr. [redacted] indicate that Petitioner's sleep functional outcome measures were the following: ESS 24/24, FSS 62/63, and PHQ-9 25. It was noted that she requires the use of a CPAP machine seven nights per week. Physical examination showed that her BMI was 59.39 and all other examined systems were normal. Petitioner was diagnosed with mild obstructive sleep apnea with treatment emergent CSA's- well controlled with BiPAP autoSV advanced device. Her high ESS score was likely due to polypharmacy with medications with sedative side effects. Additional diagnosis included restless leg syndrome for which she was on Mirapex, multiple mood/psychiatric disorders for which she was receiving multiple medications, fibromyalgia being treated with gabapentin, Percocet, and Zanaflex. (Exhibit A, pp.1914 – 1922)

Records from Petitioner's 2017 to 2018 OB/Gyn visits at [redacted] indicate that in August 2017 she presented with complaints of recurrent candida as well

as recurrent ulcers and legions that occur all over her body including on her cervix and labia. She reported that she gets them all the time in her mouth and her rheumatologist believes that she has Behcet's disease. Physical examination showed that her external genitalia appeared normal, with no lesions, with slight pink in the crural regions bilaterally. A tiny lesion with a pinpoint break in the skin was found on her right inner thigh. The doctor indicated that Petitioner sounds like she has an immune disease; however, because she is already on immunotherapy medications and is being treated by a rheumatologist, there was no further input to share. In April 2018, Petitioner presented for her annual gynecologic exam and continued to report multiple concerns that had been evaluated by other physicians including chronic pain syndrome, recurrent ulcers all over her body, suprapubic pain with a diagnosis of interstitial cystitis, and a 12 x 18mm fibroid on her uterus. There were no notable other abnormalities found upon physical examination. (Exhibit A, pp. 1933-1961)

Petitioner's July 2017 through July 2018 mental health treatment records from [redacted] were presented and reviewed. (Exhibit A, pp. 1986-2031) During a July 24, 2018 medication review appointment, Petitioner complained of anxiety, mood, and other health issues. Petitioner was observed to ambulate with the assistance of a walker. Upon mental status examination, her speech was within normal limits, her thought process seems logical, she was alert and oriented, her mood is up and down at times, affect was in full range, she had no abnormal or psychotic thinking, no suicidal or homicidal ideations, her insight and judgment appeared to be okay, her language was within normal limits, and her fund of knowledge was also within normal limits. Petitioner's prescribed medications included Seroquel, Xanax, and Zoloft. Her active diagnoses were bipolar disorder, current episode mixed, severe, without psychotic features; posttraumatic stress disorder, chronic; generalized anxiety disorder; panic disorder; and borderline personality disorder. Her GAF score was 55. During an April 3, 2018 medication review appointment, Petitioner confirmed that her Seroquel, Zoloft, and Xanax medications are helpful, although she indicated she had episodes of passing out. Petitioner indicated she has difficulty going to sleep but denies any other difficulties or side effects with her medications. Petitioner's mental status examination was the same as the July 2018 assessment. Petitioner's December 2017 medication review appointment had similar findings as the above, and Petitioner noted that she wanted to go back to psychotherapy as she had not been in therapy for about six months. (Exhibit A, pp. 1986-2031)

Physician notes from Petitioner's October 18, 2017 appointment with [redacted] indicate that she presented for a cardiac evaluation prior to a myelogram for back pain. Her cardiac physical exam showed normal rate, regular rhythm, normal heart sounds and intact distal pulses. Her effort was normal as were her breath sounds. Petitioner was diagnosed with pulmonary hypertension, postural orthostatic tachycardia syndrome, pure hypercholesterolemia, and a BMI of 58.7, severely obese. The doctor indicated that Petitioner had a normal LVEF and no significant valve disease by echocardiogram last year. The doctor concluded that Petitioner's cardiac status is stable for her myelogram and although a nuclear stress test due to IV access difficulties could

not be done, he felt that she would be low to moderate risk for her back procedure from a strictly cardiac standpoint only. (Exhibit A, pp.2032 – 2070).

Based on the medical evidence presented in this case, listings 1.02 (major dysfunction of a joint(s) due to any cause), 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), 3.03 (asthma), 3.09 (chronic pulmonary hypertension), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), 12.08 (personality and impulse-control disorders), 12.15 (trauma and stressor related disorders), 14.02 (systemic lupus erythematosus), 14.09 (inflammatory arthritis), and 14.10 (Sjogren's syndrome) were considered.

The most recent favorable decision which rendered Petitioner disabled is the June 30, 2016 DDS decision finding that at the time, her condition met a listing under 14.02B (systemic lupus erythematosus), as she was found to be morbidly obese, has fatigue and fever, is receiving treatment for obstructive sleep apnea and had difficulties with her activities of daily living.

As referenced above, the medical evidence presented with the current review showed that Petitioner continued to receive ongoing treatment for the conditions that rendered her disabled in the June 2016 DDS decision and further that she continues to have fatigue, fever, difficulties in activities with daily living, and remains morbidly obese. Additionally, the Department did not establish that there has been an improvement in Petitioner's conditions and impairments since that time, as there was insufficient evidence to show a decrease in the medical severity of the impairments. 20 CFR 416.994(b)(1)(i); 20 CFR 416.994(b)(5)(ii).

At the hearing, Petitioner testified that she continues to suffer from extreme pain throughout the day and that her lupus has been affecting her body, organs, tissues, and skin. She reported that she receives injections for her lupus weekly and that she has developed myelitis in her legs. Petitioner reported suffering from rheumatoid arthritis in all of her bones including her wrists, ankles, and feet. She also reported having two interstimulator pacemakers implanted to treat her severe interstitial cystitis which causes extreme pain and frequent urination, sometimes every three minutes. This was supported by the medical records. Petitioner stated that she is able to walk for only 1 to 1 ½ minutes before experiencing severe pain in her upper legs and lower back. She reported that she requires the use of a walker with a seat to assist her with ambulation, which allows her to sit down and rest when attempting to walk. Petitioner reported an inability to grip or grasp items with her hands due to the swelling caused by carpal tunnel syndrome and rheumatoid arthritis. She further testified that neuropathy in her hands and feet impacts her ability to grip and grasp with her hands and to walk and stand. Petitioner testified that she can sit for up to 45 minutes, depending on the type of chair. Petitioner testified that she is unable to lift more than 1 to 2 pounds and cannot lift a gallon of milk. She testified that she is unable to bend or squat due to the pain in her back and legs and that she crawls up the stairs, requiring assistance. Petitioner testified that she lives in a small apartment with her fiancé who also serves as her caregiver. She stated that she requires the use of a seat in the bathtub as she is unable to stand in

the shower due to dizziness. Petitioner testified that she is unable to bathe herself, is unable to take care of her own personal hygiene and is unable to dress herself. She reported requiring the assistance of her fiancé who is also her caregiver for all activities of daily living which also included household chores cooking and cleaning. Petitioner stated that she uses mask to assist with breathing at night due to her obstructive sleep apnea. Petitioner testified that she sometimes wakes up crying in pain and that she only leaves the house for medical appointments.

With respect to her mental impairments, Petitioner testified that she suffers from anxiety attacks which include symptoms of inability to breathe, shaking, paranoia, and that she is always in a state of worry. She testified that she can only focus for 3 to 5 minutes before losing concentration and that she has difficulty with her memory. Petitioner stated that she suffers from crying spells that last for hours and that she has had thoughts of hurting herself but not others. Petitioner reported she has self-harmed, with the most recent time being about one month ago and further, that she had thoughts and a plan for suicide in the last few weeks. She reported that she struggles daily with her bipolar disorder, that she suffers from visual and auditory hallucinations, and that she deals with a lot of darkness daily.

Upon thorough review, the medical evidence presented with the current review continues to support the prior DDS finding that Petitioner's impairments meet or are the equivalent to the required level in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabling without further consideration. Thus, Petitioner's disability is continuing at Step 1 and no further analysis is required.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner **has** a continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility **continues,** and the Department **did not act** in accordance with Department policy when it closed her SDA case.

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

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

1. Reinstate Petitioner's SDA case effective April 1, 2019;

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from April 1, 2019, ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in April 2020 in accordance with Department policy.

ZB/tlf

**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

**Via Email:**

[redacted]

**Authorized Hearing Rep. – Via USPS**

[redacted]

**Petitioner – Via Usps**

[redacted]