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Date Mailed: August 26, 2019
MOAHR Docket No.: 19-005665
Agency No.: [redacted]
Petitioner: [redacted]

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 June 27, 2019, from [redacted] Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Michelle Morley, Assistance Payments Supervisor, and Margaret Smith, Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. During the hearing, Petitioner presented Exhibit B consisting of some medical records which were received and marked into evidence. Exhibit C was received and marked into evidence and was evidence requested to be obtained pursuant to the Interim Order issued on June 27, 2010. The DHS-49-D and DHS-49-E to be completed by Mona Habib were not received. The record was closed on July 27, 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 August 2, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On April 9, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 9-15).

3. On April 16, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS finding of no disability (Exhibit A, pp. 5-8).

4. On May 29, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 2-4).

5. Petitioner alleged disabling impairment due to mental impairments including severe Anxiety, Post Traumatic Stress Disorder and Depression. The Petitioner also alleges physical impairments due to COPD and limited mobility in both wrists.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted], birth date; she is [redacted] in height and weighs about [redacted] 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 at [redacted] working as a cashier and moving freight and products and also retrieved shopping carts. Petitioner also worked as a caregiver to cancer patients. Petitioner also worked as a manager of a senior center.

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 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/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/he 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, *and in response to the interim order,* was reviewed and is summarized below.

The Petitioner received treatment for her mental impairments at AuSable Valley Community Health Authority. On [redacted] 2019, a Psychiatric Evaluation was performed. The current symptoms reported by Petitioner included notes of a long history of depression and anxiety. Her medications included Pristiq, Trazodone and Buspar; and she has taken these medications for about one year and continues to feel very depressed including hopelessness, tearfulness, anxiety and insomnia. Two traumatic events were reported, including the death of a loved one and an incident with her daughter who has paranoid schizophrenia and who attempted to kill her. Patient fears for her daughter's safety and well-being, and the daughter was hospitalized at the time

of the evaluation. Petitioner told the doctor that at times she wants to give up on life. She denied any intent to hurt herself. She is only sleeping a few hours a night. The family history notes that her mother had schizophrenia, and her sister also lived at a mental hospital in [redacted] County. The Petitioner reported a difficult childhood with a mentally ill mother and a father who was an alcoholic who were both very physically and mentally abusive to her. The Petitioner reported running away from home many times and was removed from her parents at age [redacted] to foster care until age [redacted]. At the exam, the psychiatrist reported that hygiene was within normal limits; her attitude was cooperative; her movements were normal; communication was normal as was her speech rate and rhythm; her mood was sad and dysphoric, hopeless and depressed. Affect was appropriate; thought process was intact with no impairment as was thought content. Petitioner was fully oriented and alert but exhibited impaired concentration, impaired immediate recall and long-term recall. Fund of knowledge was adequate, and intellectual functioning appeared average. Insight was fair as was judgment. Energy was rated as decreased and her ability to engage in socially acceptable interactions to establish and maintain relationships was within normal limits. The diagnosis was Major Depressive Disorder Recurrent Episode, Severe, based upon diminished interest in activities, insomnia, fatigue, worthlessness, irritability, diminished ability to concentrate, suicidal ideation and several days a week with loss of interest. The Nurse practitioner (PMHNP-BC) recommended that Petitioner needed psychotherapy on weekly to biweekly schedule for support. The dosages for all the psychotropic medications were increased.

The Petitioner was seen at [redacted] Community Health Authority on [redacted] 2018; and intake history information was reviewed. Petitioner reported no prior hospitalizations or suicide attempts and had participated with the CMH before. Petitioner was homeless at the time of the interview. The Petitioner was approved for individual therapy of 30 sessions for a one-year period beginning [redacted] 2018 ending [redacted] 2019.

A Medical Examination Report was completed on [redacted] 2019, by the Petitioner's primary care physician. The doctor has been treating Petitioner for approximately six months since her former primary care doctor left the organization. The current diagnosis was Anxiety, PTSD and memory problems. During the examination, the doctor noted slow speech and thought process. The Petitioner's left ankle was noted for swelling and tenderness. The Petitioner was noted to have slow thought process and was tearful and anxious. The doctor's clinical assessment found her condition stable. The doctor imposed the following limitations which were expected to last more than 90 days. The Petitioner was unable to lift or carry less than 10 pounds and was evaluated as unable to use her extremities (hands/arms) for repetitive action. The limitations also noted Petitioner could not operate foot pedals with either foot. No limitations were marked assessing the Petitioner's ability/limitation regarding standing/walking or sitting. The medical findings were that the patient was unable to be around people and had debilitating panic attacks with slow thought process. Her memory, sustained concentration and social interactions were noted as limited. The doctor found Petitioner could meet her needs in the home.

The Petitioner was seen for a check-up for depression and anemia on [redacted] 2019, at West Branch Primary Care. The active problems were COPD, moderate; Depression, enlarged thyroid, Hyperlipidemia, painful legs and moving toes of left foot, and PTSD. During the exam, the Petitioner's gait and station were abnormal with mild tremors as were inspection/palpation of joints, bones and muscles. Petitioner's mood and affect were abnormal due to slow responses to questions with stuttering with anxious mood and affect.

The Assessment noted malaise and fatigue, and Dyshidrosis (skin rash).

On [redacted] 2019, the Petitioner was seen to follow up and check-up regarding her wellbeing. Notes indicate that she has been attending therapy at a CMH ([redacted] taking her medications. Petitioner continues with significant anxiety. At the examination, the Petitioner's thyroid was enlarged, respiratory effort was abnormal, and expiratory wheezing, mild tremors noted as abnormal for gait and station and with also unequal grip strengths Left 1/5 and Rt 4/5. The Petitioner's mood and affect were abnormal with slow responses to questions, mood and affect was anxious. Assessment was PTSD, depression, enlarged thyroid, and COPD, moderate. An additional inhaler prescription was added as was a pulmonary function test.

The Petitioner was seen on [redacted] 2019, and reviewed for medications by [redacted] Primary Care. Here, former doctor was no longer with the practice, so Petitioner's appointment was to reestablish with a new doctor. The physical exam noted as normal except for lymph notes in neck and inspection of joints and bones were abnormal with unequal grip strength. Mood and affect were abnormal with slow responses to questions with anxious affect and tearful. The assessment was depression, PTSD and enlarged thyroid; and a referral for psychiatric outpatient was made.

On [redacted] 2019, Petitioner's primary care doctor wrote a letter stating that Petitioner is unable to work at that time due to diagnosis of PTSD, depression and anxiety as well as left wrist injury that causes pain and limited range of motion.

A pulmonary function test was conducted on [redacted] 2019, which was assessed as moderate COPD; and Symbicort was prescribed. A Sonogram of the Petitioner's thyroid was performed on [redacted] 2019. The Impression was less than 1 cm benign-appearing nodule lesion in the right and left thyroid lobe.

On [redacted] 2018, the Petitioner was seen by her then primary care doctor (Dr. [redacted] due to a severe episode of recurrent major depressive disorder without psychotic features, and COPD as well as non-seasonal allergic rhinitis. She was also seen on [redacted] 2018, for depression, at which time notes indicate she was in therapy with [redacted] CMH with some improvement of her depression. Notes indicate that Petitioner still has suicidal thoughts and works through this with counseling. Buspar medication has helped with anxiety, but she is very fatigued on this medication.

Petitioner reported that she has recurrent nightmares and sleeps in 45-minute bursts with maximum continuous sleep two hours. The Petitioner was treated for a left wrist fracture ([redacted] 2019) due to a fall. Petitioner was positive for depression. Behavior was normal. Trazadone was prescribed for insomnia.

On [redacted] 2018, Petitioner had a recheck for depression with notes that she suffers depression, sleep disturbance, and suicidal ideas, and reports tired of hurt and pain and sometimes does not want to wake up. Patient is anxious and nervous and cannot handle noise and crowds. Petitioner is also scheduled to have all her teeth extracted on [redacted] 2018. Petitioner complained of aches, daily for neck shoulder, knees, ankles and left wrist and was positive for arthralgias, myalgias, neck pain, extremity pain and joint stiffness. Petitioner exhibited depression, was tearful and anxious and delayed speech, but memory was normal. On [redacted] 2018, the Petitioner presented due to depression and exacerbation of asthma. Notes indicate that Petitioner is positive for agitation due to noise and people situations trigger to anger. Petitioner reported having difficulty filling out paperwork to get help with finances and housing. Petitioner continues to have sleep disturbance with negative thoughts at night. Petitioner presented as nervous/anxious. Notes indicate that she was unable to make a connection with [redacted] CMH and was seeking to find other counseling.

On [redacted] 2018, Petitioner was seen in Emergency Room (ER) for left wrist injury; she is right-hand dominant. Petitioner was found to have a displaced distal radius and ulna fracture with concerns for open fracture. Petitioner underwent a fracture reduction. The wound was assessed as an abrasion, and the reduction was performed and a splint placed; and Petitioner was administered morphine for pain. Diagnosis was acute closed fracture of distal end of left radius with significant shortening.

At a recheck on [redacted] 2018, the exam notes indicate Petitioner was withdrawn; her mood was anxious.

On [redacted] 2018, the Petitioner was seen for depression; and notes indicate that depression is not well-managed; and PHQ9 score was 22. Petitioner was tearful and has suicidal thought and at time plans of suicide with no active plan on date of exam. She has an appointment at [redacted] CHM for intake the next week. Sleep is described as 45-minute bursts due to nightmares. Assessment was severe incident of recurrent major depressive disorder without psychotic features. Petitioner was prescribed Desvenlafaxine for management of depression.

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

Residual Functional Capacity

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

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

Limitations can be exertional, 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 has limited mobility in her left wrist which is still painful due to a fracture and has COPD which requires use of an inhaler and is on several medications for depression, anxiety and PTSD. Her PTSD symptoms were due to her mentally ill daughter assaulting her with a weapon and resulted in the daughter being criminally charged and Petitioner obtaining a personal protection order prohibiting her daughter from contacting her. Petitioner also suffered from the loss of a loved on who she cared for four years when he had cancer and died. Petitioner is treating with

[redacted] CMH in 2018 and testified that she has had mental problems depression and anxiety all her life which she regrets ignoring. At the hearing, Petitioner was tearful and apologized for being unable to remember things. Petitioner indicated the following conditions with regard to her mental health. She has frequent crying spells every night and suffers from nightmares and difficulty sleeping. She is prescribed Tramadol to assist with her sleep problems. During the hearing, the undersigned found the Petitioner's speech inordinately slow. Petitioner has no relationships or friends other than one sister and avoids people and crowds which make her anxious and shops for groceries at night or when other people are not around, and her sister helps her make a list. The Petitioner does vacuum and does laundry. She does not like being in public due to noise. Petitioner expressed that she does have thoughts of suicide but has never attempted to take her life. She has had depression all of her life. She does not have an appetite and has no desire to eat and only makes peanut butter and jelly sandwiches; her sister makes meals for her that she can freeze. Petitioner expressed that at times she does not want to live. Her memory has diminished, and she forgets appointments or is late and has no order or routine. During the hearing, the Petitioner had delayed speech and stammered and was anxious and at times need questions repeated. The Petitioner attempts to read but due to poor concentration can only focus for a few minutes. The Petitioner does not drive due to her left wrist lack of mobility and her anxiety. She takes public transportation but is fearful when doing so. The Petitioner has been compliant with her medications. During her interview during the application process on [redacted] 2018, the caseworker noted the following difficulties exhibited by Petitioner: answering, appearance, eye contact, hearing memory, seeing, signs of fatigue, sings of pain or distress, sitting, understanding, using both her hands, walking writing and was withdrawn. The caseworker also notes "client shows very visible sign of anxiety, crying and shaking and stuttered throughout the interview." When asked for her address and date of birth, she had to get her driver's license and Social Security card to provide the information. Petitioner's showering is sporadic and could not recall if she showers every day. The Petitioner uses the bus and is helped by the bus personnel. Petitioner's primary care doctor, who prescribes her medications for depression, PTSD and anxiety, noted that during her most recent evaluation Petitioner had a slow thought process and slow speech and was tearful and anxious. The doctor noted that Petitioner was unable to be around people and had debilitating panic attacks. The doctor also noted that Petitioner's memory and concentration were limited.

Petitioner's mental health evaluation also notes that Petitioner told her she often wants to give up on life, but did not have any intent to hurt herself and also noted sleep is disrupted sleeping only a few hours a night.

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 the following limitations on her mental ability to perform basic work activities. The Petitioner's ability with respect to performing activities of daily living are moderately impaired; her social functioning is markedly impaired; and her concentration and memory are markedly impaired. There were no episodes of decompensation presented. Based upon the evidence, it is determined that the Petitioner's non-exertional impairments significantly interfere with her ability to function independently, appropriately, effectively, and on a sustained basis. *Id.*; 20 CFR 416.920a(c)(2).

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 cashier at [redacted] which also required lifting of freight weighing up to 30 pounds and lifting grocery bags into carts and retrieving shopping carts from the parking area. This work required light physical exertion. Petitioner also was a caregiver, and based upon her reporting was required to shop, prepare meals, driving to doctor appointment and lift no more than 10 pounds and as such was light work. The Petitioner's work as a manager of a senior center food program required sedentary work doing office work and some recordkeeping and typing and writing but did not require much if only occasional supervision of others but did involve interaction with the public. Petitioner's work at the senior center required walking and standing occasionally and keeping simple records and lifting less 10 pounds or less and as such required sedentary physical exertion.

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 including her [redacted] job and caregiving as they involve light work. The Petitioner could not perform the senior center job due to her impaired ability to be around noise and public crowds as well as her primary care doctor's limitations imposed with respect to her using her hands for repetitive action. Petitioner also has moderate-

to-marked limitations in her mental capacity to perform basic work activities. In light of the entire record, it is found that Petitioner's non-exertional RFC prohibits her from performing past relevant work.

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

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 [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be advanced age (age 55 and over) for purposes of Appendix 2. She is a high school graduate with a history of work experience as a cashier and stocking freight, caregiver and working in a senior center doing office work. While two of the jobs, cashiering and stocking and caregiving involve light work, the senior center job is evaluated as sedentary, however, involved significant contact with the public. 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. As previously analyzed above, due to her non-exertional limitations based on her mental impairments, she has a non-exertional RFC

imposing marked limitations in her social functioning and marked limitations in her concentration and memory. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of her non-exertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the 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. Reregister and process Petitioner's August 2, 2018, SDA application to determine if all the other non-medical criteria are satisfied, and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in August 2020.

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 Office of Administrative Hearings and Rules (MOAHR).

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

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

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

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

DHHS (via electronic mail)

Angela Neubecker
MDHHS-Ogemaw-Hearings

BSC4
L Karadsheh

Petitioner (via first class mail)

[redacted]
[redacted]
[redacted] MI [redacted]