GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

Date Mailed: August 30, 2019
MOAHR Docket No.: 19-005897
Agency No.:
Petitioner:

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 July 1, 2019, from Detroit, Michigan. The Petitioner was represented by herself and a witness also appeared on behalf of Petitioner. The Department of Health and Human Services (Department) was represented by , Hearing Facilitator.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Exhibit B was received and marked into evidence and consists of medical records provided by the Petitioner at the hearing. Exhibit C contained medical records in response to the Interim Order which were received and marked into evidence. The items in the Interim Order that were not received was a DHS 49 from Dr. and the psychological evaluation from of Lansing, Michigan. The record closed on July 31, 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 February 6, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On April 25, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 4-10).

3. On May 1, 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. 495-498.

4. On, May 24, 2019 the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 495).

5. Petitioner alleged disabling impairment due to carpal tunnel in her right hand, severe migraines with vertigo, trigeminal neuralgia in the face, COPD, reactive airway asthma and also alleges mental impairments due to PTSD, Borderline Personality Disorder, Depression and Anxiety.

6. On the date of the hearing, Petitioner was [redacted] years old with a July 8, [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 as a clerical worker doing data entry, cashier at retail stores, working at an assisted living facility as a cook/server, bookkeeper at a water delivery service and cafeteria jobs.

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, s/he 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.

The Petitioner underwent a Psychological Evaluation on January 22, 2019. The evaluation was conducted pursuant to a court order to assess [redacted] [redacted] current psychological function, cognitive function, parenting capacity and mental health needs. The report was later forwarded to the [redacted]. It appears that various records involving mental health treatment and an inpatient admission were reviewed by the examiner preparing the evaluation. It also concerned a child custody Complaint involving Petitioner's daughter. The report describes several descriptions of hallucinations experienced by Petitioner, and hearing voices. In addition, the reports also contain a summary of Petitioner's fiancé kicking her daughter in the ribs and that child appeared to be neglected and malnourished. The child was removed from her father as he admitted he was unable to care for his daughter. The

child was placed in foster care. A post investigation summary notes a preponderance of evidence that the child was harmed or placed at risk of harm by the actions of her father.

The evaluation also contains notes reviewed by the examiner of prior assessments of Petitioner. At the time of the assessment her fiancé had left Michigan with Petitioner's daughter and was residing in [redacted]. At the time of the evaluation the Petitioner had not cared for her daughter for over a year.

During the interview the Petitioner described a history of domestic violence with her fiancé and other men. Also reported by Petitioner was a history of substance abuse beginning at age [redacted] which included alcohol, marijuana and pharmaceuticals. The Petitioner reported no history of substance abuse evaluation or treatment. During the interview the Petitioner reported a history of receiving mental health services. Petitioner also described that her doctor prescribed medications that helped her stop her panic attacks. The Petitioner reported no history of self-injurious ideation, intention or behavior. The Petitioner described flashbacks that occurred as picture memories when her fiancé [redacted] would throw furniture out the front door. She also has night terrors during periods of high stress reporting one several weeks ago. The Petitioner was administered the Mini Mental State Exam used for assessing cognitive mental status. MMSE results suggest that Petitioner was alert, attentive and oriented to time, place, location and situation. It also showed language, memory and the ability to follow simple commands in the normal range of functioning.

The Petitioner was also administered a Test of Nonverbal Intelligence (TONI-3) and used to measure intelligence, aptitude, abstract reasoning and problem solving without use of language. Test results placed Petitioner's nonverbal intelligence in the above average range of cognitive functioning with a standard score of 119 (83rd) percentile ranking.

The Petitioner was also administered the Millon Clinical Multi-Axial Inventory-III which seeks to identify enduring personality characteristics to assess personality disorders and clinical syndromes. The test also includes a validity scale to help indicate the extent to which a respondent is "faking good" or "faking bad" on the test. The examiner noted there were no intentional efforts to distort the test by the Petitioner. The results also suggest that overall a negative self appraisal. The results indicate that Petitioner may be characterized as anxious, attention seeking, compulsive, dependent, depressed, overly demanding, self-centered, self-defeating, socially indifferent, submissive, tolerant of abuse and uncommunicative with general disregard for the welfare of others. She may be fearful of criticism and rejection. The results suggest she may be characterized by limited driven ambition, emotional withdrawal, and feelings of inadequacy, insecurity and low self-esteem. Results indicate Petitioner may be easily confused and experience irrational thoughts and exhibit occasional outbursts of anger and aggression that surface through her normally composed demeanor.

The evaluation also contained a mental status examination/clinical interview section. The notes indicate that Petitioner was oriented to time place and person with fluid and coherent speech with no notable aphasia. Memory was grossly intact for recent and remote events and the mood was described as mildly anxious. During the interview Petitioner exhibited no notable depression symptoms or agitation. No current self injurious ideations or plans were described. The Petitioner's clinical presentation included no loose or tangential thought associations and suggested no intrusive internal stimuli or delusions. The Petitioner's judgment and insight were considered limited for her current adjustment needs. She was cooperative throughout the interview.

At the time of the evaluation the Petitioner was not receiving psychiatric services but was seeing a therapist. Petitioner presented no evidence suggesting an immediate risk of impulsive physical harm to herself or anyone else. She presented no sign of uncontrolled agitation, no verbal or physical aggression and no confrontational provocations. She was determined to be psychologically stable enough to participate in an interview with out uncontrolled negative consequences. Her involvement in current Department of child protection arose in in May or June when she called them looking for her daughter. The Petitioner has been participating by phone for the various court dates involved with respect to custody of her daughter.

The clinical considerations included by the examiner involve Petitioner's reported family history of substance abuse domestic violence and psychiatric illness. Her personal history includes physical abuse, fighting in school, substance abuse, domestic violence, homelessness and currently restricted contact with her daughter. Her psychiatric history includes hospitalization and treatment for anxiety, depression and trauma related symptoms. The Petitioner's overall psychological well-being may benefit from improvements in four areas which include social, emotional, cognitive and behavioral domains of experience. Social targets include reducing exploitative relationships, developing and maintaining a stable substance free, violence free, health promoting, supportive childcare environment and developing and maintaining assertive communications skills, nonconfrontational conflict resolution strategies. Emotional targets include reducing feelings of fear, sadness and anger. Cognitive targets include acknowledging personal shortcomings, reducing avoidant fantasies, reducing hostile thoughts, and reducing thoughts associated with inadequacy, insecurity, rejection, resentment, suspicion and low self-esteem. Behavioral targets include reducing provocative interactions and verbal aggression, eliminating residential instability and maintaining drug and alcohol abstinence and treatment, training, and medication compliance if applicable.

Therapeutically the examiner determined the Petitioner was likely to resist treatments and she may perceive it as an effort to undermine her psychological defenses. Once trust is established, she may benefit from an exploration of her repressed anger and resentment, explore her history of personal victimization. Genuine progress may be slow and difficult. Moreover, without ongoing confidence, initiative and willingness to assume responsibility, Petitioner may become superficial, evasive and noncompliant in the treatment process.

The diagnosis given by the examiner included bipolar disorder, posttraumatic stress disorder, dependent personality disorder with borderline features, parent-child relational problems and history of physical abuse and domestic violence. The examiner included that Petitioner exhibits no cognitive functioning deficits that would affect her capacity for parenting, continued learning or maturation. She does however exhibit thought and behavior patterns that may affect her decision-making, her ability to control interpersonal conflict, her ability to maintain an independent social life and her ability to benefit from psychotherapy. Due to areas of psychological dysfunction the Petitioner is hindered in her capacity for normal adulthood. Emotionally, evidence suggests that Petitioner experiences mood swings, chronic anxiety and elevated levels of sadness and anger associated with her history. Cognitively evidence suggest that Petitioner experiences thoughts associated with avoidance of emotional discomfort, inadequacy, insecurities, suspicion, rejection, resentment, hostility and low self-esteem. Evidence further suggests that Petitioner may currently exhibit social dependency, interpersonal exploitation, verbal aggression, possible physical aggression and residential instability.

In conditions of personal instability, interpersonal conflict, substance abuse, homelessness, untreated psychiatric symptoms or multiple overlapping stressors, all of these functions are likely to be significantly impaired. Personality deficits were listed as mood swings, low stress tolerance, hostility, impulsivity, limited initiative, submissiveness and dependency. She may also be suspicious, exploitive, avoidant of emotional discomfort and lacking in psychological insight. These combined characteristics would contribute to increased confusion, anxiety and poor decision-making that might lead to substance abuse, domestic conflict, inadequate parenting and child neglect. During the last year and half the examiner noted that Petitioner experienced homelessness, sexual exploitation and was treated for psychiatric symptoms including anxiety, depression and irritability.

The following recommendations were made by the examiner. The Petitioner should have a medication review with a licensed prescribing clinician focusing on treatment for mood stability, improved attention function and the reduction of anxiety and agitated depression symptoms. At the conclusion it was recommended that Petitioner should not currently be considered capable of adequately parenting her daughter on an independent basis. Specific areas of concern include her residential instability, her financial instability, her risk for domestic violence, her risk for treatment noncompliance, her need for supportive mental health services and her likely need of continued psychiatric services. It was recommended that the Petitioner's contact with her daughter be maintained under supervision. It further concluded that given the duration of the child's current placement and the uncertain prognosis for her parents' long term stability it is recommended that all efforts be made to ensure that the child can ultimately be placed in a permanent stable nurturing environment.

The Petitioner was psychologically assessed on April 16, 2019 at the [redacted] [redacted] This was therapy offered by her [redacted] and accepted by Petitioner. This was an intake assessment due to her need for treatment and struggles with interpersonal relationships having experienced domestic violence with some of her past romantic

relationships, anxiety, depression, and a feeling of being unable to trust others. An assessment of the validity of the results based on Petitioner's response style notes that her responses were consistent, meaning that she gave similar responses to similar questions and was able to attend appropriately to test items and understood the meaning of questions., Her scores were significant for positive impression creation to suggest she portrays herself as someone who is free relatively of common shortcomings to which most individuals will admit to and is somewhat reluctant to recognize minor faults in herself.

During the mental status and behavioral observation the notes indicate her gross and fine motor abilities were intact, she was able to attend to the test materials and respond to the questions. Her rate and flow of speech fell within normal limits. Her thought pattern was logical and linear. At times she needed redirection to the topic at hand, which she was very receptive to. She made appropriate eye contact and her attitude indicated a willingness to cooperate. Her outward expression of emotion was consistent with the content of her speech. She denied having any current active or passive suicidal ideation's or intent. During the exam the Petitioner reported that she has a migraine disorder which is chronic and for which she takes medications. She stated she experiences auras and sometimes experiences olfactory hallucinations (smelling something that is not there). She takes gabapentin and inhalers for her asthma/COPD. During the exam Petitioner reported she occasionally uses marijuana as a sleep aid and pain reducer. She reported she only takes her prescribed medications as indicated. She denied any current or recent problems with substance abuse.

The Petitioner reported experiencing nightmares and physical responses such as sweating, heart racing which are the most severe and bothersome symptoms. Thus, she experiences symptoms associated with trauma, including intrusive memories of traumatic events with physical reactions when reminded of those events as well as experiences difficulty sleeping. The Petitioner also reported fluctuation in appetite and feeling down or hopeless, with fatigue and feeling bad about herself and moving more slowly than usual, psychomotor retardation. The summary and conclusion included a diagnosis of major depressive disorder and notes that she meets the criteria for posttraumatic stress disorder and her score fell just below the diagnostic threshold, however, the examiner opined that it was reasonable to assume she may have under reported her symptoms. Specifically, Petitioner's diagnostic presentation is consistent with Battered Woman Syndrome a subset of PTSD that applies to specific types of posttraumatic stress with clients experiencing domestic violence often, women with BWS experience an increase in chronic pain issues as well as psychological phenomena such as learned helplessness. A diagnosis of major depressive disorder was considered but ultimately ruled out. While Petitioner does experience some depressive symptoms, they do not reach the threshold necessary for diagnosis. This does not mean, however that the depressive symptoms will not be relevant for treatment.

At the conclusion of the exam the treatment recommendation was that Petitioner received full DBT therapy consisting of five modes of treatment including individual

therapy, group therapy, skills coaching and an optional trauma treatment for people with PTSD as well as team consultation. DBT therapy will help Petitioner learn how to focus on the present moment without holding judgments; practice interacting with others effectively without emotions getting in the way; manage and reduce vulnerability to intense negative emotions and implement distress tolerance skills in a crisis or when her emotions threaten to impair her ability to function.

On May 1, 2019 the [redacted] Counselor who serviced the Petitioner wrote a letter regarding her recommendations and conclusions with regard to the Petitioner's participation in rehabilitation services. The Petitioner was found eligible for the program due to her mental health disorders and her neurological disorder. The counselor found that Petitioner's ability to maintain employment at this time was greatly affected by her emotional and physical limitations. During the program Petitioner was provided supported employment services which is a team approach providing a higher level of support to those seeking employment. She was put in a supported community rehabilitation program setting so as to evaluate her ability to work and maintain employment. Petitioner was not able to meet the requirements of the job due to her disability symptoms. It was determined that she was not ready to be placed in a community employment setting. The rehabilitation counselor, who held a MA, CRC stated that in her professional opinion, Petitioner will have a very difficult time obtaining and maintaining employment at a gainful employment level. She requires significant supports and flexibility in scheduling in order to meet everyday employment requirements. See BEM 261 (April 2017), p. 2, which provides a participant in MRS who has a signed Individual Plan for Employment (IPE) is eligible for SDA. No IPE was presented in this case by Petitioner and it appears she was unable to be placed in a community employment setting.

The Petitioner's treatment records by her neurologist were also reviewed. On August 24, 2018, the Petitioner was seen by her neurologist and presented with trigeminal neuralgia. Symptoms reported included facial pain with onset approximately four years ago. Symptoms occur intermittently. The patient described her condition as moderate in severity but worsening. The pain is in the upper brow, cheekbone and jaws always on the left side with episodes of memory lapse, confusion and difficulty holding conversations at the time. During the examination the Petitioner described incidents where she would fall due to leg weakness with no loss of consciousness. She further described episodes of speaking gibberish as described by others. She described her neuralgia as neuralgia attacks with vertigo. Petitioner also reported history of migraines with aura. The Petitioner is currently taking gabapentin 600 mg five times a day which has helped but symptoms are starting to worsen. Her symptoms increase and worsen during her menstrual cycle. At the time of the exam the Petitioner indicated she had not had any hallucinations, mood changes or suicidal thoughts. She also noted no difficulty concentrating, dizziness or falling. The physical examination included a neurologic exam was essentially normal as was her mental status examination. The assessment and plan included trigeminal neuralgia, and acute confusional migraine and a new medication was prescribed. The doctor's notes indicate that many of the symptoms are related to migraine she has aspects of confusional migraine with catamenial component

and TAC. Also discussed was Petitioner's long-standing anxiety and depression issues which exacerbate migraine symptoms and thus concluded getting those to improve is an important part of successful treatment.

The Petitioner was seen again by the neurologist on September 24, 2018. The exam was needed as Petitioner reported having trouble with coordination and has been falling frequently. At the time of the visit she had light sensitivity and a mild headache. Petitioner reports loss of her job due to not being able to keep up a fast pace. She reports falling a few times. Her symptoms and patterns include her menstrual cycle, déjà vu feeling, lightheadedness, nausea and speech difficulties. She also reported hair loss upon taking Lamictal. She is not sleeping well since starting Depakote. During the examination the Petitioner was very tearful. The Petitioner reported times when her language was impaired and severe neuralgia attacks particularly on the left side of her face and dizziness. Symptoms worsen typically around her menstrual cycle. The prescription given at the previous visit was discontinued as it was suspected to be causing gait instability. Notes indicate that she has had some improvement with anxiety and depression since starting Depakote.

On November 20, 2018 the Petitioner was seen by her neurologist for a recheck due to recent problems with coordination and falling. At the time of the exam the Petitioner continued psychotherapy for anxiety and depression and had started a return to work program. The notes indicate she is currently doing well.

On January 7, 2019 the Petitioner was seen by her neurologist with reports that her symptoms have worsened. During the examination the Petitioner reported having fallen a couple times in the last two weeks has experienced vertigo issues, and dizziness which is more frequent. The Petitioner has been participating in physical therapy for her hips, however still feels she is having coordination issues. Recently prescribed Propranolol has helped somewhat with anxiety, but she has not noticed a significant difference with any other symptoms. Petitioner also reported difficulty with short-term memory such as forgetting conversations and difficulty falling asleep. The Petitioner was also started on Buspirone. The notes indicate the neurologist intended to start Petitioner on anti-seizure ER pediatrics. Concerned that starting this treatment may be difficult due to Medicaid coverage.

During 2018 the Petitioner's treating Neurologist Dr. [redacted] completed a letter indication that Petitioner was under his care for a neurological condition and reports of worsening of symptoms that may make it difficult for her to work certain jobs. The doctor also noted in the letter if there were questions, he should be contacted. The date on the copy of the letter cannot be read to determine the month it was written.

The Petitioner was seen for physical therapy prescribed by her doctor due to hip pain and falling with coordination problems at times. The Petitioner attended weekly sessions to strengthen her hips.

On November 27, 2018 the Petitioner was seen at her primary care physician's office for hip pain with an onset of one day ago the location of the pain was the left hip without radiation. The pain causes petitioner to fall, noting she fell in the driveway near the bus stop she twists and get sharp pain which triggers the fall. The physical exam noted that the petitioner's gait was cautious however her left hip was in normal alignment. The Petitioner was prescribed ibuprofen and to apply heat or ice every 20 minutes for additional pain relief. The diagnosis assessment was chronic left pain. The Petitioner was seen again on November 16, 2018 and indicated that her therapy was extremely beneficial and she was emotionally feeling better Her trigeminal neuralgia on the left side of her face has improved with gabapentin. The Petitioner was advised to follow up with her neurologist. On September 5, 2018 the Petitioner sought assistance and treatment due to confusion on the job and is worried about losing her job. The Assessment and plan were that the Petitioner was to follow up with her neurologist and her CMH case manager due to missing multiple appointments. In April 2018 the Petitioner was seen at her primary doctor's office for depression due to a breakup of a relationship in which she was physically abused. Presents with anxious/fearful thoughts, depressed mood, difficulty staying asleep, diminished interest or pleasure, excessive worry and fatigue without hallucination or thoughts of death or suicide. Also, complaints of worsening dizziness left-sided facial trigeminal neuralgia and memory issues. The assessment for depression was to follow up with the CMH she was presently attending and her gabapentin was increased. Notes in the exam indicate a comment that Patient's mood and affect were incongruent with severity of symptoms described.

The Petitioner has received mental health treatment from ████████████████ ██ █████████ and in Ingham Counties beginning in May 2017 when she was assessed and referred herself for counseling. At the time the Petitioner reported she suffers from "irrational fears" which she would like a better level of control over. She would also like to experience a decrease in her level of anxiety. At the time she was not taking any psychotropic medications and she reported that in the past she thought they had begun to work for her. At the time of the referral she was not working. The Petitioner also reported health concerns involving what she labeled as vertigo and has fallen in the past because of dizziness. She sometimes has difficulty with her memory especially short-term. She was not seen by a primary care physician at the time. At the conclusion of the evaluation the Petitioner was recommended for outpatient therapy and was diagnosed with panic disorder. The notes indicate the mental status of Petitioner was normal with good eye contact, clear speech, and regular rate. The examiner also noted that her thought content had some paranoia without any hallucinations or suicidal ideation. Her insight was fair. The examiner also noted borderline personality disorder in his assessment and prescribed psychotropic medications. Shortly after this assessment the Petitioner did not attend appointments or participate in services and so the relationship with the CMH was ended.

The Petitioner was admitted for inpatient treatment in August 2017 after reporting to the emergency department due to experiencing visual hallucinations after the birth of her daughter. The hallucinations were described as seeing blood and spiders and included symptoms of tremors, vertigo, confusion, agitation, paranoid behavior, migraines,

incontinence of bladder and bowels and occasional thoughts of suicidal ideation. Petitioner expressed that the symptoms appeared to be hormonally related with her menstrual cycles and neurologically related. The notes indicate the Patient was nervous and anxious. At the time of the exam the Petitioner's mood was normal and she was not actively hallucinating nor was her thought content delusional. Her affect was tearful. Notes indicate the Petitioner appeared desperate for help. The Petitioner denied any use of alcohol and marijuana at the time. Lab results confirmed no on prescribed drug use or illegal drugs. The psychological exam noted Petitioner's affect to be depressed, anxious, despair, helpless, guilty, terrified, worthless with low self-esteem. Her attention span noted easily distracted and both her insight and judgment were deemed impaired. She also reported suicidal ideation. At the time she was diagnosed with unspecified other psychotic disorder. Also noted was that Petitioner's behavior was considerably influenced by delusions or hallucinations or, serious impairment in judgment, and communication with inability to function in almost all areas the Petitioner was admitted to the hospital.

The Petitioner resumed treatment for her mental health and illness on or about April 19, 2018 with the same CMH she had attended previously. Petitioner received crisis services. At the time of that intake interview, the notes indicate that the clients thought process was logical but disconnected with tangential reality and confusion. She denied hallucinations and did not appear to be responding to any internal stimuli. She also denied paranoia and delusions with pressured/anxious speech. The Petitioner reported panic attacks and anxiety due to history of trauma in her romantic relationships. At the time of the interview her grooming was appropriate, her appetite and sleep was stable, and she was not taking medication for her mental health issues. At the time of this visit her diagnosis/description was major depressive disorder, single episode moderate. The Petitioner was to reengage for treatment the following day.

The Petitioner reengaged with community mental health on April 24, 2018 seeking services and had been homeless for a number of months. She had been referred to CMH age by her former therapist due to his belief that she needed a higher level of care. Stressors in Petitioner's life were due to her ex-fiancé leaving the state with her two year old daughter. On May 7, 2018 the Petitioner's diagnoses was panic disorder based on a final assessment as well as major depressive disorder, single episode, moderate. Notes further indicate that Petitioner is hopeful about interviewing for a job at the [redacted]. On May 17, 2018 the Petitioner reported for her initial session in therapy. At that meeting she presented as clean, well-groomed and due to her homelessness and stress her sleep patterns were affected but she is able to care for herself and her basic needs. Petitioner's speech was pressured but clear and presented with clear, focused and logical speech patterns. She at times became distracted but could get back on topic. Demonstrated the ability to problem solve and use concrete thinking skills. There was no evidence of thought disorder. Judgment and insight were guarded but she denied harm to herself or others. Petitioner's mood was anxious, depressed with some hopelessness but she was goal oriented to her new job and finding a way to reunite with her daughter. The subsequent notes from May 22, 2018 indicate that she was employed and liked her job a lot.

The Petitioner has continued to treat with her CMH mental health care provider during the period August 2018 through February 2019 approximately every week, sometimes every other week. The Petitioner was seen for individual therapy on November 9, 2018 and was in good spirits with adequate grooming, had applied for an apartment. Notes indicate that Petitioner is practicing good boundaries, participating in employment coaching, denied any ongoing concerns. Insight and judgment were good. On November 19, 2019 the Petitioner had been to New Jersey to see her daughter. The Petitioner arrived early for her appointment. Petitioner was seen on December 4, 2018 and had a periodic review. Petitioner advised things were going well. Petitioner's physical symptoms were improving this month. Petitioner was seen on December 13, 2018 and had made plans to travel to New Jersey to see her daughter. Petitioner made all submissions required to complete her apartment application. She had also obtained a letter from her Neurologist about her ability to work. Mood was stable. On December 20, 2018, continued working with her neurologist still having some migraine symptoms though mentioned less and less looking more steady on her feet, no tremors. Doing well. On January 11, 2019 Petitioner was on time, notes indicate that Petitioner is continuing to do well emotionally. The Petitioner had insights into her past relationships and her patterns. On January 18, 2019 notes indicate that Petitioner was told she was unable to be placed due to her limited functionality and risks by the job coaching. Notes indicate she was feeling a bit dizzy. On January 24, 2019 Petitioner was on time and had visited with her daughter in New Jersey. Petitioner missed her transfer flight but was able to manage and made next flight without issue. On February 4, 2019 the Petitioner was on time for her appointment and was having more neurological symptoms leading to more depression and frustration. Petitioner denied stress; however the notes indicate that symptoms are increased due to stress related to child custody of her daughter, missing a call, housing being held up, medications not working and food benefits ending, and her boyfriend has not secured a job. Therapist suggest DBT therapy and Petitioner was receptive. On February 20, 2019 Petitioner had participated by phone in a court hearing regarding her daughter and other than some trauma reaction due to her ex fiancé, the child's father being on the call, she has been doing well still. Petitioner was awaiting transitioning to DBT therapy. Petitioner has obtained her apartment and is ready to move in. The February 20, 2019 visit was the last medical record in the file.

The Petitioner completed a Function Report-Adult as requested by Social Security March 5, 2019. The Petitioner comments that her symptoms are unpredictable day today indicating that someday she has vertigo and coordination problems that she falls or injures her hands, sometimes cannot understand language for short periods with intense anxiety, and experiences dizziness after physical exertion even without anxiety. The petitioner indicates that she experiences sleep problems with difficulty "slowing down", going to sleep with nightmares. For personal care she indicated that she must be seated or leaning on something. The Petitioner also states that sometimes her memory is good and she experiences confidence. On bad days when things are worse, she starts forgetting taking her pills and things spiral, therefore she needs an alarm to take her medications.

With respect to activities of daily living including housework her activities very throughout the day and she indicated she can take care of most things when her symptoms are at a minimum. The Petitioner also indicates that she does not drive due to vertigo attacks and sometimes has difficulty interpreting meaning such as red equal stop or green equals go and confuses left and right. The petitioner does shop for groceries and does shop online. The Petitioner indicate she does not go out for social activities but does communicate with friends by phone or Internet a few evenings a week the petitioner also reported losing a job at [redacted] due to difficulties getting along with a new supervisor the reported unusual behaviors or fears noted constant nightmares, experiences jumpiness and startling, often feel attacked verbally and feels helpless when symptoms of migraine come on. Most of the abilities that involved physical actions were due to experiencing vertical and coordination problems which are variable. Her ability to walk was also noted as wildly variable because on good day she could walk three or four blocks recovering within 2 to 3 minutes and on bad days walking down the hallway is all she can do. The Petitioner noted she could pay attention for a half-hour to an hour and can follow written instructions if she can refer back to them. It is more difficult to follow spoken instructions. The petitioner also notes that episodes were less severe for a while in 2018 but have flared up while working at [redacted] and have been severe ever since.

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 11:00 Neurological disorders and a recent Social Security Ruling SSR19-4p concerning guidance for evaluation of a medically determinable impairment of a primary headache disorder which is not a listed impairment but can be found to meet a listing. Based upon a review of the medical evidence provided there is insufficient information as required by the SSR such as an observation of a typical headache event and a detailed description of the event by the Petitioner's doctor. The SSR was effective August 26, 2019. In addition, listing 12.06 Anxiety and obsessive-compulsive disorders and 12.15 Trauma stressor -related disorders, 1.02 Major Dysfunction of a Joint were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as

disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

Residual Functional Capacity

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

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

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

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

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). In addition, four broad functional areas (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 nonexertional limitations due to her medical condition. Petitioner testified that on a "good day" she could walk around the block several times and on a "bad day" she could only walk across the house. Petitioner can sit for several hours, and is able shower and dress herself, tie her shoes and touch her toes. Petitioner is right-handed but testified that she favors her left hand because her right hand shakes. Petitioner testified that 15 pounds was the heaviest weight she could carry with her left arm hand due to lack of coordination. Petitioner testified that she has sleep difficulties due to nightmares, and twitches, which cause her to wake up. Petitioner gets up for the day between 8am and 11am. Petitioner is able to grocery shop and shop online.

With respect to her mental impairments Petitioner testified that she has anxiety attacks which make her shaky and nervous with racing thoughts, shortness of breath several times a week. She cries for no reason. She conceded that she has anger issues when vulnerable and becomes aggressive, but did not do so when she worked. She expressed no suicidal ideations or hallucinations currently, but does have auras from her migraine. Petitioner expressed her depression has been helped by Wellbutrin causing her to not be as overwhelmed. Petitioner reported her appetite was good. The hearing facilitator also advised that she left several messages regarding the hearing time for Petitioner. Petitioner's headaches also vary sometimes with auras. The DHS representative at the hearing also indicated that Petitioner's memory was not good, and that she had to repeat her conversation with Petitioner and go over it again because she

was confused. The Petitioner can cook a simple meal, and helps with vacuuming and laundry. The Petitioner also testified that she experiences vertigo and the ground is moving causing her to sit down if standing; these episodes can last from five minutes to an hour and occur four to five times a week. Petitioner also testified that she falls, and her legs give out.

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 in light of her reports of falling and vertigo as defined by 20 CFR 416.967(a). Although Petitioner's medical evidence indicated a diagnosis of migraine and trigeminal neuralgia the frequency of falling and vertigo as testified by Petitioner to occur four to five times a week is not consistent with the reports made to her doctor and the notes contained in her medical records. The neurologist in his letter in 2018 suggests that Petitioner cannot work at some jobs but does not indicate what the limitations are and thus is not helpful. Also considered was the letter from the Michigan Rehabilitation counselor who indicated that Petitioner was placed in the program due to her mental health disorders and neurological disorders. and put in a supported community setting so as to evaluate her ability to work and maintain employment. Petitioner was not able to meet the requirements of the job due to her disability symptoms as reported in March 2019. In addition, the Petitioner's treatment records from her weekly psychotherapy would indicate that she is doing much better on medications and functions pretty well cognitively even with some stress. The most serious symptoms previously experienced by Petitioner such as hallucinations, were during a period where she was not on any psychotropic medications. Given the Petitioner's reported falling and vertigo, the Petitioner has limitations as to heights and ladders.

Based on the medical record presented, as well as Petitioner's testimony, Petitioner has some nonexertional limitations on her mental impairments and her ability to perform basic work activities due to her mental disorders variously diagnosed as panic disorder, anxiety and post traumatic stress disorder. Based upon a review of the documented treatment notes and Petitioner's testimony, Petitioner has mild limitations in performing activities of daily living. Petitioner's social functioning is moderately impaired due to having minimal social contact with friends and her main contacts consist of contact with her doctors and therapists. Petitioner does have a moderate to marked impairment with concentration, memory and pace based upon treatment notes, and her lack of success with the [redacted] in successfully being able to meet the requirements of performing a job in a highly supportive environment. Finally, Petitioner's notes and self-reporting of the loss of her last cashier job at the [redacted] demonstrate inability to maintain employment due to having trouble getting tasks done,

making errors with money, and insubordination. A response filed by Petitioner as part of the SSA Function Report indicates that when in a migraine episode, the Petitioner reports that she was called by her supervisor and could not understand the supervisor's rapid speech. Petitioner went to the place of employment and in her own words nearly got arrested because she did not understand what her supervisor was saying. She was fired and not allowed in the store. The Petitioner is able to keep her weekly appointments and for her therapy and appears on time for appointments. Given this evidence it is found that Petitioner has the physical capacity to perform sedentary work and is able to do simple repetitive work with one or two steps required in a low stress environment.

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 doing data entry for Medicaid claims, cashiering at retail stores, working at an assisted living facility as a cook/server, and as a bookkeeper for a water delivery services as well as cafeteria jobs. Petitioner's work as cashier required standing much of the day and keeping track of change and money and some stocking. This job required a physical exertion level for light work. The Petitioner's job as a cook required cooking and serving meals for 100 people and required standing/walking much of the day and lifting objects up to 20 pounds and required light physical exertion. Petitioner's job as a bookkeeper required tracking deliveries and generating invoices and billing as well as making a delivery schedule which while sedentary, requires too much detail and involves several steps and a varying level of responsibility which goes beyond Petitioner's current capabilities due to her memory, concentration and pace issues. Likewise, Petitioner's job performing data entry which involved Medicaid claims would require a level of detail which Petitioner could not sustain even though it requires physical exertion on a sedentary level.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to no more than sedentary work activities and ability to perform simple repetitive tasks in a low stress environment due to her nonexertional limitations. As such, Petitioner is incapable of performing past relevant work. Petitioner also has moderate to marked limitations in

her mental capacity to perform basic work activities with regard to memory, concentration and pace. In light of the entire record, it is found that Petitioner's nonexertional 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).

However, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2).

When a person has a combination of exertional and nonexertional 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 ██ years old at the time of application and ██ years old at the time of hearing, and, thus, considered to be a younger individual (age ████) for purposes of Appendix 2. She is a high school graduate with a history of work experience as a cashier, cook, bookkeeper and data entry. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

Based solely on her exertional RFC, the Medical-Vocational Guidelines, 20 CFR 416.967(a), result in a finding that Petitioner is not disabled.

However, Petitioner also has impairments due to her mental condition. As a result, she has a nonexertional RFC imposing moderate to marked limitations which affect her concentration, persistence or pace. It is found that those limitations would not preclude her from engaging in simple, unskilled work activities on a sustained basis. Therefore, Petitioner is able to adjust to other work and is not disabled at Step 5.

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.

DECISION AND ORDER

Accordingly, the Department's determination is AFFIRMED.

LMF/tlf

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

Via Email:

Petitioner – Via First-Class Mail: