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

Date Mailed: September 11, 2019
MOAHR Docket No.: 19-006220
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Zainab A. Baydoun

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on July 11, 2019, from [redacted] Michigan. Petitioner appeared for the hearing with his Authorized Hearing Representative (AHR) [redacted] and [redacted] as a support person. The Department of Health and Human Services (Department) was represented by Michael Thomas, 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. Petitioner submitted additional records which were received, marked and admitted into evidence as Exhibit 1. The record was subsequently closed on August 12, 2019 and the matter is now before the undersigned for a final determination on the evidence presented.

ISSUE

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

FINDINGS OF FACT

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

1. On or around February 19, 2019, Petitioner submitted an application for cash assistance on the basis of a disability.

2. On or around May 29, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. The DDS determined that Petitioner was capable of performing other work.

3. On June 6, 2019, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 528-531)

4. On June 14, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of his SDA application.

5. Petitioner's case file indicates he also requested a hearing to dispute the Department's actions with respect to the Family Independence Program (FIP); however, Petitioner confirmed that there was no issue concerning his FIP benefits and thus, the request for hearing was withdrawn and will be dismissed.

6. Petitioner alleged physically and mentally disabling impairments due to fetal alcohol syndrome, developmental delay, PTSD, severe personality disorder, brain aneurysm, migraine, stroke, chest pain, shortness of breath, seizures, and frontal lobe brain damage.

7. As of the hearing date, Petitioner was [redacted] years old with a [redacted] date of birth; he was [redacted] and weighed [redacted] pounds.

8. Petitioner completed high school through a special education program and has reported employment history of work as a store clerk at [redacted] Petitioner has not been employed since July 2017.

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

CONCLUSIONS OF LAW

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

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), 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, he is not ineligible at 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 thoroughly reviewed and is briefly summarized below:

Records from Petitioner's mental health treatment at Behavioral Health: [redacted] Medical Center and [redacted] for Mental Health were presented and reviewed. (Exhibit A, pp. 182-249, 386-460). A Psychosocial Evaluation completed on [redacted] 2019 indicated that Petitioner was referred for treatment because he was moody with lots of aggression and had complete confusion. It was noted that he spent two hours trying to figure out how to use the microwave and could not remember to turn it on. There were also notes that Petitioner threatened to kill himself and others, that he was born with fetal alcohol syndrome and has suffered numerous concussions. Physical, sexual, and emotional abuse was reported by Petitioner as a child. He reported that he was kicked out of regular high school and had to attend alternative education for children with learning disabilities, as he is unable to comprehend what he reads. Mental

status exam notes showed that Petitioner had impaired short-term memory, and it was reported that Petitioner had a suicide attempt in the three months prior to the evaluation. He also reported suffering from auditory and visual hallucinations and has frequent thoughts to end his life. A psychological consultation completed on [redacted] 2019 indicates that he was referred for psychological testing to rule out mental retardation or qualification as a developmentally disabled adult. During the consultation, it was reported that Petitioner tried to enlist in the Army, but he ended up beating up his drill sergeant and was, as a result, dishonorably discharged as unfit because of mental health problems. He described a marginal adjustment to adult life, never being able to hold a job due to his explosive temper and poor work habits. He reported history of being involved in a serious motor vehicle accident at age [redacted] while on a bike, a result of which he sustained a severe closed head injury and spent a week in a trauma ward in [redacted] Ohio. The psychologist noted that many of Petitioner's responses during the testing session were about aggression, violence, and sex. It was noted that Petitioner did not appear to have much self-esteem but one of the things he boasted about was his ability to fight and inflict damage. A Weschler adult intelligence scale (WAIS) and Wide Range Achievement Test (WRAT – R) were administered. His performance on the WAIS resulted in a verbal IQ of 79, a performance IQ of 78, and a full-scale IQ of 78. This places him in the borderline range of intelligence. The test for intellectual disability is an IQ of 70 ± in the presence of significant adaptive behavior problems and social judgment, social understanding and other areas of adaptive functioning. Petitioner met the diagnostic criteria for intellectual developmental disorder. On the WRAT – R, his performance resulted in beginning 11th grade reading level, 7th grade spelling level and an 8th grade arithmetic performance. The recommendation was that Petitioner should probably apply for Social Security disability and that he would likely qualify for developmentally disabled or DD case management and job placement services. His presentation strongly suggested severe personality disorder (antisocial/borderline personality disorder). It was noted that he could profit from participating in a Marsha Linehan type borderline treatment program eventually replacing the current pride in his interpersonal violence with positive self-esteem. (Exhibit A, pp. 182-249, 386-460).

On [redacted] 2019, Petitioner was admitted to [redacted] for inpatient mental health treatment under a petition in the first clinical certificate. He initially presented to the emergency room due to having suicidal and homicidal ideations. A psychiatric evaluation was completed on [redacted] 2019. Petitioner reported that he has been finding himself dealing with a depressed mood and irritability. According to the petition completed by his brother, Petitioner had been fairly aggressive and violent towards his brother which raised a concern. He had apparently also been violent towards the family cat and was found to have strangled and thrown the cat. Although Petitioner presently denied having any suicidal thoughts, he reported over the past week or so these thoughts have been intensifying. He denied having any homicidal ideations but vividly remembered becoming agitated with his brother. Petitioner complained of symptoms spanning across a multitude of different psychiatric disorders. With respect to depression, he reported that he finds himself feeling depressed more days of the week than actually feeling euthymic. He stated that his sleep is poor and is attributed mainly to having intractable migraine headaches that typically occur in the early morning hours.

He stated that the headaches feel like someone is squeezing a vice around his head which then produces tears and dizziness to the point of him losing balance. He additionally complained of feelings of helplessness, hopelessness, and worthlessness. He reported difficulty concentrating and it was noted that he had mild memory impairments with declarative functioning. With respect to his psychotic symptoms, Petitioner reported that he purchased the mobile home from someone who had passed away in the trailer. He feels that the trailer might be haunted and stated that on occasion, he hears voices saying “come on, let’s go.” He reported experiencing auditory hallucinations and that sometimes he sees things out of his peripheral vision. He had a rich history of neglect and physical abuse stemming from his early childhood years as he reported being the victim of physical, emotional, and sexual abuse. He reports that he does have intrusive thoughts quite a bit where he thinks about all various forms of trauma almost on a daily basis, reporting that if he ever met up with the sexual perpetrator, he would kill him. The credibility of this ever happening was noted to be fairly minimal however, considering that the individual who sexually raped him is currently serving time in prison. Petitioner reported being admitted into a psychiatric facility nearly 20 years ago, but the circumstances surrounding the admission were difficult to follow. According to chart documentation reviewed, Petitioner may have overdosed on Vicodin and Maxalt about five months prior and notes indicate that he had been diagnosed with adjustment disorder and established services through [redacted]. His primary care physician, [redacted] was managing his psychotropic medications. Petitioner had past medical history which included a cerebral vascular accident, cerebral aneurysms with two stents placed, a one-time seizure episode, a double hernia, hyperlipidemia, and Gerd. The admission mental status exam noted that Petitioner speech was of a loud, irritable, and agitated tone, his motor exam was significant for psychomotor agitation as he has various physical gesticulations by slapping his hands on the table as he speaks. His thought process is tangential and needs frequent redirection. He does have some paranoid delusions about his home being haunted, his mood was described as irritable, and his affect was congruent. His insight and judgment were both marginal. His attention and concentration were also both marginal. It was recommended that a second certification be completed for Petitioner to remain hospitalized, considering he was having suicidal and homicidal ideations. Although he was presently voluntarily wanting help, he comes across as being a bit unpredictable. His prognosis was guarded and it was estimated that he would remain hospitalized for 5 to 7 days. [redacted] 2019 progress notes from the inpatient treating psychiatrist indicate that per staff, Petitioner was problematic last evening, as he was yelling at staff and banging his head against the wall and windows. Today he presents as labile, escalating between being angry and pleasant. He has pressured speech, tangential thought processes, and was demanding and impulsive. He indicated he is worried that he will be violent towards his brother if he returns home and questions if he will go to jail if he assaulted his brother. Notes indicate that his MoCA was 22/30, which can support a diagnosis of neurocognitive impairment, albeit he had a history of fetal alcohol syndrome. (Exhibit A, pp. 182-249, 386-460).

Petitioner was discharged from his inpatient treatment on [redacted] 2019. He was discharged with a diagnosis of unspecified mood disorder, alcohol use disorder in

remission, history of fetal alcohol syndrome, cluster B traits, history of COPD, history of aneurysm and cerebral vascular accident, benign prostatic hyperplasia, history of hypnic headaches, and hyperlipidemia. His discharge mental status exam indicated that his thought content was free of suicidal ideations, however, he endorsed having a desire to hurt his brother's friend but reported he would not actively go looking for him. Notes indicate that during his hospital course, he was observed to be extremely agitated, irritable, and dealing with insomnia that generally stemmed from having unrelenting migraine headaches that would typically occur in the early morning hours. He exhibited features consistent with mania throughout the initial phase of treatment, as he was extremely irritable, pressured with his speech, impulsive, irrational, argumentative and dealing with distractibility. His symptoms are treated with mood stabilizing medications to target manic like behaviors and symptoms. Neurology consult indicated that Petitioner was dealing with a variant of migraine headaches. He was discharged from treatment in an improved state. Although his mood had stabilized, there were concerns that he continued to endorse having homicidal ideations toward his brother's friend whom he did not like. Petitioner was to follow up with continued outpatient mental health treatment. Progress notes from [redacted] 2019 indicate that concerns were noted that Petitioner was not taking his medications as prescribed, as he is becoming very argumentative and agitated. (Exhibit A, pp. 182-249, 386-460).

A CT of Petitioner's head completed in [redacted] 2018 showed a prior right temporal craniotomy with no acute fracture and a suspected focal expansion or perhaps vascular clip, nonmetallic, in the vicinity of the supraglenoid right internal carotid. It was noted that the head was abnormal in appearance, aneurysm versus postsurgical appearance. (Exhibit 1)

Petitioner was receiving treatment from [redacted]. He was referred for treatment in [redacted] 2019 for alteration of consciousness and recalled one time in [redacted] 2018, he had an episode where his arms were stiff, and he was brought to the emergency room. His main complaint was headaches which were described to be bifrontal and occurring on a daily basis. He identified symptoms of chest discomfort, breathing problems, dizziness, history of hallucinations and sleep difficulty. He has past medical history which included hypertension, headaches, depression, seizure, stroke, COPD, and surgery for a brain aneurysm. Records indicate that Petitioner was evaluated by a prior neurologist when he was admitted for treatment and was thought to have hypnic headache disorder for which he was receiving lithium treatment. It is noted that he may have suffered a subarachnoid hemorrhage [redacted] years ago associated with cerebral aneurysm. Progress notes from a [redacted] 2019 visit indicate that upon review of prior CAT scan results, evidence of a possible nonmetallic vascular clip in the right supraclinoid vicinity was found and a recent EEG study showed bifrontal sharp wave activity. Notes indicate that Petitioner reported continuous feelings of dizziness and that he "goes down" briefly with recovery. Petitioner was assessed as having chronic headache disorder, convulsions with dizzy spells, possible seizure disorders, and an abnormal EEG which noted evidence of neuronal irritability in both frontal areas. His medication treatment was adjusted. (Exhibit 1)

Petitioner was receiving cardiology treatment for chest pain, shortness of breath, hypertension. (Exhibit A, pp. 107-126). On [redacted] 2019, Petitioner underwent cardiac catheterization due to persistent chest pain and progressive exertional dyspnea. (Exhibit A, pp.518-519)

Results of Pulmonary Function Testing completed on [redacted] 2019, show that his FVC was 3.9, 83% of predicted. FEV1 was 2.5, 73%. FEV1/FVC ratio is 62%. There was a severe reduction in flows of lower lung volumes, the total lung capacity is 113%, residual volume 166%, diffusion capacity 98%. He was given a bronchodilator. He underwent a methacholine challenge test and had a significant drop in FEV at stage by the testing, indicating degree of bronchial hyperactivity. The impression was that Petitioner had moderate obstructive lung disease with hyperinflation, air trapping. Diffusion capacity was preserved and his methacholine was positive, indicating a degree of bronchial hyperactivity. He received continued treatment for COPD and used inhalers daily. (Exhibit A, pp. 154-170,336-337)

On [redacted] 2018, Petitioner underwent a left and right hernia repair at [redacted] Hospital. Notes indicate that prior to the surgery, Petitioner complained of left lower discomfort, bulging on both sides of his groin, constipation, and a previous hernia repair three years prior. (Exhibit A, pp. 132-153)

Records from Petitioner's [redacted] 2018 to [redacted] 2019 treatment at [redacted] were presented and reviewed. (Exhibit A, pp. 177-188, 253-314). Progress notes from a [redacted] 2019 office visit indicate that he had a fall four days prior and hit his head on the wood paneling, but there was no loss of consciousness, or seizure like activity. His last appointment with the neurologist [redacted] was 1 to 2 weeks prior and he underwent EEG testing the day before. It was noted that Petitioner is fighting with his brother and upset by this. He also reported persistent decreased lung function and progressive shortness of breath on exertion that began in [redacted] 2018. Petitioner reported shortness of breath with normal activity, back pain, complaints of anxiety and feeling stressed. In [redacted] 2019, Petitioner reported frequent dizziness and falling three times in the last 36 hours. He reported suffering from daily migraines and multiple traumatic brain injuries due to boxing and hitting head to try and relieve the pain. Difficulty remembering day-to-day activities was noted as was Petitioner exhibiting symptoms of anger. He complained of recurrent fatigue, headache, weakness and sleep disorders. Additional complaints of painful joints, muscle aches, weakness, back and neck pain stiffness and arthritis were noted as was feelings of panic, stress, depression and anxiety. Records indicate that Petitioner was being treated for generalized anxiety disorder, depression, migraine, cerebellar ataxia, hypercalcemia, short-term memory loss, PTSD, muscle spasms of the lumbar region, chronic insomnia, dyspnea on exertion, hypertension and lead exposure. (Exhibit A, pp. 177-188, 253-314).

Petitioner received treatment in the emergency department of [redacted] from [redacted] 2018 to [redacted] 2018. Records indicate that he presented with an episode of generalized shaking and stiffness of all extremities and tachypnea as witnessed by his family, associated with generalized headache. He complained of mild

pleuritic chest pain, feeling visibly anxious, but denying any weakness or numbness of his upper or lower extremities. Due to the history of seizure activity, a CT scan of the head was performed which showed abnormal results and thus Petitioner was admitted for observation and a CTA, which was negative for pulmonary embolism and there was no evidence of abnormal enhancements in the brain. (Exhibit A, pp. 366-495)

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 3.02 (chronic respiratory disorders), 12.02 (neurocognitive disorders), 12.04 (depressive, bipolar and related disorders), 12.05 (intellectual disorder), 12.06 (anxiety and obsessive-compulsive disorders), and 12.08 (personality and impulse control disorders), 12.15 (trauma-and stressor-related disorders) were considered.

The medical evidence presented does not show that Petitioner has physical or exertional impairments that meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. However, upon thorough review, and in consideration of Petitioner's presentation during the hearing, as well as the above referenced medical documentation of Petitioner's mental impairments: including his involuntary inpatient hospitalization, recurrent auditory and visual hallucinations, anger outbursts, memory difficulty, documented suicidal and homicidal ideations, diagnosed intellectual developmental disorder, sleep disturbances/insomnia related to his migraine headaches, as well as his documented history of physical, emotional, and sexual abuse induced PTSD, were sufficient to establish that, when combined, the impairment meet or are equal to the required level in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabled. Accordingly, Petitioner **is disabled** at Step 3 and no further analysis is required.

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 hearing request with respect to FIP is **DISMISSED** and the Department's SDA 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 February 19, 2019 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; and

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

ZB/tlf

Zainab A. Baydoun
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

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

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

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

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

Via Email:

MDHHS-GR8North-Hearings
BSC1 Hearing Decisions
Policy-FIP-SDA-RAP
MOAHR

Authorized Hearing Rep.
- **Via First-Class Mail:**

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

Petitioner
- **Via First-Class Mail:**

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