[redacted]

Date Mailed: September 5, 2019
MOAHR Docket No.: 19-006197
Agency No.: [redacted]
Petitioner: [redacted]

**ADMINISTRATIVE LAW JUDGE: Jacquelyn A. McClinton**

## HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250; and 45 CFR 205.10. After due notice, a telephone hearing was held on July 18, 2019, from Detroit, Michigan. Petitioner appeared on his own behalf. Participants on behalf of the Department of Human Services (Department) included Renee Trudeau, 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. Records from [redacted] (BHS) and [redacted] were received and marked into evidence as Exhibit 1; *The record closed on* August 7, 2019*,* and the matter is now before the undersigned for a final determination based on the evidence presented.

## ISSUE

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

## FINDINGS OF FACT

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

1. On [redacted], 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On May 14, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 2-8).

3. On May 20, 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. 233-236).

4. On May 29, 2019, the Department received Petitioner's timely written Request for Hearing (Exhibit A, pp. 237-239).

5. Petitioner alleged disabling impairment due to migraine, depression, anxiety, muscle weakness, hypersomnia, chronic cough, numbness in face and vertigo.

6. On the date of the hearing, Petitioner was 28 years old with a [redacted], 1991 birth date; he is 5'11" in height and weighs about 260 pounds.

7. Petitioner obtained a bachelor's degree.

8. At the time of application, Petitioner was not employed.

9. Petitioner has an employment history of work as a database administrator and an assistant program manager.

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**,** 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.

On February 22, 2018, Petitioner was seen at [redacted] with a chief complaint of a cough. Petitioner described the illness as moderate. There was no hoarseness, nasal congestion or discharge, sinus pressure or ear pain. The clinical impression indicated acute upper respiratory infection and anxiety reaction. Petitioner had a chest x-ray completed. There was no acute cardiopulmonary disease. (Exhibit A, pp. 184-188).

On February 23, 2018, Petitioner was seen at [redacted] with a chief complaint of a cough. The cough was noted to have begun the day before and was still persisting. Petitioner underwent a CT Angio Chest. There was no evidence of pulmonary embolus; no acute intrathoracic pathology; and mild splenomegaly. (Exhibit A, pp. 175-183).

On March 5, 2018, Petitioner was seen at [redacted] as a result of a referral from the ear, nose and throat doctor. The referral was based on concerns regarding history of coughing frequently during and after eating drinking. Petitioner was noted to have a spontaneous cough throughout the evaluation. Petitioner had normal oral and pharyngeal phases of the swallow. Normal oral phase coordination and swallow trigger timing. Petitioner had excellent pharyngeal muscle strength with no evidence of penetration or aspiration. Relating to swallowing, Petitioner's current status was listed as 0 percent impaired, limited or restricted. (Exhibit A, pp. 170-174).

On May 1, 2018, Petitioner underwent an electroencephalogram. The results were normal; no focal, lateralized, or epileptiform features were noted. (Exhibit A, p. 198).

On May 8, 2018, Petitioner underwent an x-ray of the cervical spine. There was no significant degenerative disc disease or dynamic instability. (Exhibit A, p. 166).

On May 9, 2018, Petitioner underwent an MRI Cervical w/wo contrast. There was mild straightening of the normal cervical lordosis as well as some very minimal early degenerative disc disease. (Exhibit A, p. 167).

On August 18, 2018, Petitioner was seen at [redacted] as a result of a motor vehicle collision. The location of the injuries was noted as the head, neck, chest, abdomen, upper back and left hip. Petitioner complained of moderate pain and indicated that he sustained a blow to the head, possibly by the airbag. The record noted that "[t]he accident involved two vehicles and a low impact velocity and resulted in moderate damage to patient's vehicle." A CT was performed with normal results. The impression was contusion to the anterior chest and minor closed head injury with no loss of consciousness. Petitioner also had an x-ray of the abdomen and cervical spine. There was no evidence of bowel obstruction, perforation or acute pulmonary disease in the abdomen. The cervical spine x-ray revealed minor scoliosis in the upper cervical spine. It was noted that there was little change compared to the study of May 8, 2018, which preceded the motor vehicle accident. (Exhibit A, pp. 138-147).

On August 21, 2018, Petitioner underwent a Multiple sleep Latency Test (MLST). The diagnosis was Idiopathic Hypersomnia. The record indicated that Petitioner slept in all 5 naps with an average sleep latency of 2.8 minutes with REM periods. (Exhibit A, pp. 148-165).

On October 21, 2018, Petitioner was seen at [redacted] with a chief complaint of paresthesia. The record indicates that the issue began the night before but was gone as of the time of the visit. Petitioner underwent a CT Head without contrast. The impression indicated no acute intracranial pathology. (Exhibit A, pp. 131-137).

On November 6, 2018, Petitioner underwent an MRI at [redacted]. The MRI was completed due to complaints of middle cerebral artery (MCA) stroke, numbness, and left upper extremity weakness. The MRI was normal with no acute intracranial pathology. (Exhibit A, p. 130)

On December 6, 2018, Petitioner was seen at [redacted] for a follow up visit. Petitioner was transitioning from a specialist provider. Petitioner presented with a migraine. Topamax decreased the severity to 2 per month. Petitioner was also treated for migraine headaches on May 1, 2018; May 14, 2018, May 23, 2018; June 7, 2018, July 27, 2018, September 11, 2018 and November 13, 2018. The record indicated that Petitioner has had a normal MRI, unremarkable EEG, unremarkable MRI of the cervical spine and no abnormalities with his lab tests. Under the assessment, it was noted that Petitioner's "description of his headaches are not consistent with classic migraine much less hemiplegic migraine." (Exhibit A, pp. 118-122).

On January 3, 2019, Petitioner was seen at [redacted] for a follow up appointment. It was noted that Petitioner was no longer following up with his neurologist. It was further noted that Petitioner self-diagnosed himself with hemiplegic migraines. Petitioner was scheduled to go to the headache clinic on December 31, 2018 but had to reschedule the appointment until January 17, 2019. The record noted that Petitioner has had multiple episodes of stroke like symptoms but that all testing, including MRI, MRA, EEG and a recent CT had been negative. (Exhibit 1, pp. 30-34).

On January 14, 2019, Petitioner was seen at [redacted] at the neurology clinic for a consultation for chronic migraines. The assessment indicated that Petitioner's frequency and presentation of symptoms was consistent with chronic migraines. It was noted that Petitioner's sensations were likely the result of hypervigilance due to chronic migrainous headaches. Petitioner was given the option to choose to initiate Botox treatment or to begin taking Verapamil. Petitioner opted to begin Verapamil. (Exhibit 1, pp. 34-37).

On February 7, 2019, Petitioner was seen at [redacted] to review his progress with his idiopathic hypersomnia and the medication he employs to control it, which is Modafinil. Petitioner was noted to have a cough about every minute. Petitioner stated that since he began Verapamil, his headaches were better. Petitioner further stated that he was sleepy with Modafinil but did not fall asleep during the day like he used to. The impression indicated hypersomnia and assorted neurological symptoms. (Exhibit A, pp. 210-214).

On March 21, 2019, Petitioner was seen at [redacted] and presented for an evaluation of sinus pain. Petitioner's symptoms included: congestion, facial pain, headaches, purulent rhinorrhea, sinus pressure, sore throat and ear discomfort. The onset of the symptoms was eight days prior to the visit. The assessment included no acute bacterial sinusitis and neck pain. (Exhibit 1, pp. 38-44).

On April 10, 2019, Petitioner was seen at [redacted] with a chief complaint of an ear problem. Petitioner indicated that the pain is worse in his left ear. Petitioner continued with his cough. The assessment indicated ringing in ear, bilateral and cough. (Exhibit 1, pp. 45-51).

On June 3, 2019, Petitioner was seen at [redacted] (BHS) presenting for intake with report of worsening symptoms of depression. Petitioner reported that he was unable to function in everyday living. Petitioner indicated that he sits on the couch all day and cries. Petitioner was determined to meet the criteria to receive Community Mental Health (CMH) services with a link to psychiatric services, employment services and possible therapy down the line. Petitioner indicated that his primary care physician suggested that he began depression medication. (Exhibit 1, pp. 1-17).

On June 6, 2019, Petitioner was seen at [redacted] complaining of anxiety. Petitioner indicated that his last panic attack was the day prior to the visit. The assessment indicated anxiety and depression as well as panic attacks. (Exhibit 1, pp. 58-61).

On June 11, 2019, Petitioner was seen at [redacted] relating to chronic migraines and a variety of other neurologic symptoms including facial numbness, chronic vertigo and autophobia. Petitioner was referred to a neuro-otology and was maintained on his current medication. (Exhibit 1, pp. 62-64).

On June 18, 2019, Petitioner was seen at [redacted] for case management services. A case management plan was development which was noted to expire in one year. (Exhibit 1, pp. 18-29).

On June 24, 2019, Petitioner was seen at [redacted] for left arm pain. The assessment indicated left median nerve neuropathy. It was believed that Petitioner may have had his median nerve irritated during the blood draw. Anti-inflammatories and ice were given. (Exhibit 1, pp. 65-68).

On July 18, 2019, Petitioner was seen at [redacted]. Petitioner received a botulinum toxin Type A injection for chronic migraine. Petitioner tolerated the procedure well and there were no immediate complications. (Exhibit 1, pp. 69-70).

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 11.02 (epilepsy), 11.14 (peripheral neuropathy), 12.04 (depressive, bipolar and related disorders) and 12.06 (anxiety and obsessive-compulsive disorders) were considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3 and the analysis continues to Step 4.

**Residual Functional Capacity**

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

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

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

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

involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi). For mental disorders, functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. Id.; 20 CFR 416.920a(c)(2). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3), to which a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could dress/undress himself; bathe/shower himself; use the bathroom unassisted; eat unassisted; prepare microwaveable meals; and walk. Petitioner testified that he cannot stand for a long period of time due to balance issues. Petitioner further testified that he could not bend at the waist; reach; and kneel due to vertigo.

Petitioner also indicated that he has to write information down in an effort to remember things. Petitioner indicated that he can complete simple tasks if there are no distractions. Petitioner testified that he does not work well with people as he gets angry. Petitioner testified that he cares for cats and that he enjoys sewing as a hobby.

Petitioner has a history of migraines. All objective testing such as MRIs have been found to be normal with no neurological deficits. Petitioner's gait is normal without the need of an assistive device. Petitioner has a history of hypersomnia which is medically monitored and treated with medication. There is no end organ damage noted.

Petitioner has a history of chest pain. All objective testing such as x-rays have been unremarkable.

Petitioner has a history of depression and anxiety. Petitioner is currently treating with a therapist. Petitioner has had no hospitalizations within the past 12 months. There was no medical evidence of any suicidal or homicidal ideations.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b). Based on the medical record presented, as well as Petitioner's testimony, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities. Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

**Step Four**

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as a database administrator and an assistant program manager. Petitioner's work as a database administrator, which required little standing and no heavy lifting, required sedentary physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than light work activities. Additionally, Petitioner has mild to moderate limitations on his mental ability to perform basic work activities. As such, Petitioner is able to perform past relevant work. Accordingly, Petitioner is not disabled at Step 4 and the assessment ends.

## DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

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

JAM/tlf

**Jacquelyn A. McClinton**
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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

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

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

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

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

**Via Email:**

MDHHS-906UPSHearings
BSC1 Hearing Decisions
Policy-FIP-SDA-Rap
MOAHR

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

[redacted]