[redacted], MI [redacted]

Date Mailed: October 3, 2019
MOAHR Docket No.: 19-007934
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 August 27, 2019, from Lansing, Michigan. Petitioner was represented by Petitioner [redacted]. The Department of Health and Human Services (Department or Respondent) was represented by April Nemec, Hearings Facilitator. Petitioner waived the timeliness standard and requested to submit additional medical information. The record was left open until September 15, 2019.

Respondent's Exhibit A pages 1-1481 were admitted as evidence. Petitioner submitted Petitioner's Exhibit 1 pages 1-40, which were admitted as evidence. On September 5, 2019, the additional medical evidence was received then the record closed, which were admitted as evidence of Petitioner's Exhibit 2, pages 1-53.

ISSUE

Whether the Department properly determined 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], 2018, Petitioner filed an application for SDA benefits alleging disability.

(2) Petitioner receives Medical Assistance (MA) benefits and Food Assistance Program (FAP) benefits.

(3) The application was sent to the Medical Review Team.

(4) On [redacted], 2019, Petitioner filed a second application for State Disability Assistance.

(5) On [redacted], 2019, Petitioner submitted another a third application for State Disability Assistance which was approved in error from June 1-August 31, 2019.

(6) On May 24, 2019, the Medical Review Team denied Petitioner's application stating that Petitioner could perform work other work.

(7) On July 22, 2019, the Department Caseworker sent Petitioner notice that her application was denied.

(8) On July 26, 2019, Petitioner filed a request for a hearing to contest the Department's negative action.

(9) On August 6, 2019, the Michigan Administrative Hearing System received a hearing summary and attached documentation.

(10) On August 27, 2019, the hearing was held.

(11) Petitioner is a 54-year-old woman whose date of birth is [redacted] 1965. She is 5'2" tall and weighs 200 lbs. Petitioner has a GED.

(12) Petitioner can read and write. She has basic math skills.

(13) Petitioner last worked in 2010 as a home health aide.

(14) Petitioner alleges as disabling impairments: anxiety, depression, bi-polar disorder, herniated disc, bulging disc, osteoarthritis, carpel tunnel syndrome in both hands, right ankle surgery, and hypertension.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

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

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment. 20 CFR 416.929(a).

> ...Medical reports should include:
>
> (1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, X-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms). 20 CFR 416.913(b).

The person claiming a physical, or mental, disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for a recovery and/or medical assessment of ability to do work-related activities, or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged. 20 CRF 416.913.

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include:

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability. 20 CFR 416.927(e).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the

> guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends, and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

At Step 1, Petitioner is not engaged in substantial gainful activity. Petitioner is not disqualified from receiving disability at Step 1.

The subjective and objective medical evidence on the record indicates:

Petitioner testified on the record that she lives with her adult children. She is a widow. Petitioner has no income. She receives medical assistance and food assistance program benefits. Petitioner does not drive, cook, grocery shop, or clean her home. Sometimes, she sews, but her hands hurt. She watches television four to six hours per day. The heaviest weight she can carry is 10 pounds. She smokes a pack of cigarettes per week and her Doctor has told her to stop. She is not in a smoking cessation program. She slipped and fell and broke her ankle on January 28, 2019. Petitioner can stand five to ten minutes. She can sit for three hours. She can walk 55 steps. She uses a shower chair and can dress herself. She cannot squat, tie shoes, bend at the waist, or touch her toes. Her level of pain on a scale from one to ten without medication equals a nine and with medication equals a seven.

This Administrative Law Judge did consider the entire record in making this decision.

Medical documentation indicates a non-severe condition.

Petitioner's Exhibit 1:

On October 22, 2018, an x-ray of the lumbar spine revealed no acute fracture or dislocation as seen involving the lumbar spine. Mild lumbar degenerative changes are seen at lower three levels. Reduced disc space seen at L5-S1 and L4-L5 level. Alignment of spine is satisfactory. Vertebral body heights are well maintained. Bone mineralization is normal. Bilateral pedicles are symmetric. Bilateral sacroiliac joints are grossly intact. Nonobstructive bowel gas pattern is seen in visualized abdomen. Multiple phleboliths are seen with hemipelvis on both sides. Changes to prior cholecystectomy is noted. (Petitioner's Exhibit 1 pages 1-2)

An x-ray of the left knee reveals osteoarthritis of the left knee. (Petitioner's Exhibit 1 page 3)

A cervical spine x-ray reveals diffuse cervical spondylosis. The combination of endplate spurring and facet arthropathy results in severe bilateral foraminal narrowing from C4-C5 to C6-C7. (Petitioner's Exhibit 1 page 6)

A January 10, 2019, an MRI of the lumbar spine reveals small disc protrusion on the left T11-T12 partially included on the study. Disc bulging left foramen L2-L3 without

significant foraminal stenosis. Small disc protrusion disc bulge in L5-S1. Small disc protrusion left lateral recess but not compressing the S1 nerve root. The left neural foramen however is moderately narrowed at this level with crowding of the L5 nerve root. (Petitioner's Exhibit 1 page 10)

A December 18, 2017, radiology report, MRI of the right knee indicates tricompartmental osteoarthritis. She has a tear of the posterior horn of the medial meniscus and small intra-articular effusion with loose body inferior to the patella. (Petitioner's Exhibit 1 page 12)

Respondent's Exhibit A:

A May 1, 2019, Michigan Disability Determination Service Psychological Report indicates that Petitioner was diagnosed with persistent depressive disorder with anxious distress and other substance related disorders. She was able to manage her own funds cognitively but has a history of substance abuse. Her prognosis was fair regarding mental and cognitive functioning. Petitioner is mentally capable of understanding, tending to, remembering and carrying out instructions related to a wide variety of unskilled to semiskilled work-related behaviors according to the medical source reporter. The medical resource reporter did not see any significant evidence of cognitive or adaptive deficits which would suggest overt limitations in her ability to engage in basic activities of daily living including fund management. She would likely experience mild limitations within the larger group, conventional workplace setting regarding abilities related to social interactions and ability to respond appropriately to coworkers and supervision and to adapt to changes stress. In the same vein, due to her reported symptoms, mild limitations may also be realized at this time regarding her ability related to perform activities within a schedule, at a consistent pace, maintaining regular attendance, being punctual with the customary tolerances, and completing the normal workday in work week without interruptions from psychological symptoms. (Respondent's Exhibit A pages 757-760)

A February 11, 2019, follow-up indicates that Petitioner reported that she has been smoking cigarettes. She drinks alcohol but does not use drugs. Her blood pressure was 93/61, pulse 60, temperature 36.6°C. Her body mass index was 37.31 and oxygen on room saturation was 99%. She appeared well nourished and was in no stress. Her head was normocephalic and atraumatic. In the eyes, the conjunctive and EOM were normal. The neck had normal range of motion. The pulmonary chest effort was normal. She had tenderness but no edema. She had normal range of motion. No swelling, no effusion, no crepitus, no deformity, no laceration, no spasm, normal pulse and normal strength. There was decreased range of motion in the right foot. She had normal mood and affect. Her behavior was normal. Her skin was warm and dry. She was not diaphoretic. Neurologically she was alert. (Respondent's Exhibit A pages 984-985) Petitioner had surgery on her right ankle with no complications. (Respondent's Exhibit A page 992)

A January 28, 2019, consultation note indicates that Petitioner came to the hospital with a closed right bimalleolar ankle fracture dislocation. She was unable to be counseled

because she was inebriated. She was treated and released in stable condition. Post reduction films show a reduced talus. (Respondent's Exhibit A page 598)

A January 28, 2019, consultation report indicates that Petitioner's blood pressure was 128/91. Her pulse was 94. Temperature 36.3°C. Respiration 18. She was alert and oriented times zero. She was somnolent and unable to be aroused. She did withdraw to pain. She had lower extremity edema and deformity of the right ankle but there were no open wounds. There was some dry skin and ecchymosis over the ankle. (Respondent's Exhibit A page 603)

An x-ray of the pelvis dated January 28, 2019, indicates that there was no evidence for acute fracture. No erosion changes are noted. An x-ray of the chest indicated the heart was normal size. Lungs were clear of consolidating infiltrates. No masses, nodules or effusions noted. (Respondent's Exhibit A pages 610-612)

A January 28, 2019, x-ray of the chest indicates stable chest x-ray without evidence for acute infiltrates or effusions. Heart is normal size. Lungs are clear of consolidating infiltrates. No masses, nodules or effusions noted. (Respondent's Exhibit A page 310)

A January 20, 2019, x-ray of the chest indicates no acute cardiopulmonary process. There are no plural effusions. There is no pneumothorax. (Respondent's Exhibit A page 579)

A November 2, 2018, physician's operative report indicates that that Petitioner had right carpal tunnel syndrome release and repair. Petitioner tolerated the procedure well. She was transferred to the recovery room in stable condition. (Respondent's Exhibit A page 20)

A September 20, 2018, report indicates that Petitioner was seen for neurological follow-up visit. She continued to have numbness and tingling involving the hands. Trigger point injection over the median nerves bilaterally was used without complications. EMG showed no evidence of new radiculopathy or neuropathy. X-ray of hands and wrists show degenerative changes. EEG was within normal limits. The patient was asked to use hand braces with B6 vitamin. She was also asked to exercise the neck routinely and had no need for epidural steroid injection or physical therapy. No need for carpal tunnel surgery. She will continue with Lyrica. (Respondent's Exhibit A page 146)

An August 29, 2018, report indicates that there was a normal brainstem auditory evoked response study bilaterally. This is suggestive of normal conduction between distal III nerve and low brainstem bilaterally. The inter-peak latency between one through three, three through five and one through five was within normal limits bilaterally. (Respondent's Exhibit A page 1035)

An August 24, 2018, neurological evaluation indicates that vital signs are stable. The patient was alert and oriented times three with normal mentation and cognition. Central language function was normal. Correct examination revealed no bruit bilaterally. Cranial

nerve examination reveals pupils equal and reactive to light and accommodation, full eye movements without nystagmus, full visual fields to confrontation, sharp discs bilaterally, tongue midline without deviation or for circulation and normal gag and corneal reflexes. Motor examination reveals normal tone, bulk and muscle strength of all muscle groups at 5/5. Deep tendon reflexes are 2+ symmetrically. No cerebellar dysfunction to nose finger nose or heel to shin. Rapid alternating movements are normal. Gait is normal including tiptoe, heel walk and tandem gait. Sensory examination is normal to pinprick, light touch and temperature. (Respondent's Exhibit A page 143) The impression was bilateral carpal tunnel syndrome, cervical spondylosis and muscle contraction headache. (Respondent's Exhibit A page 144)

A mental status evaluation dated December 10, 2018, indicates that Petitioner is diagnosed with persistent depressive disorder and posttraumatic stress disorder as well as active cannabis use disorder. Rule out anxiety disorder and bipolar disorder. Her cocaine dependence, polysubstance dependence in remission and resolved. (Respondent's Exhibit A page 162) Petitioner presented as neat and clean in appearance. Speech rate, volume and tone of voice were normal. Denies any suicidal or homicidal ideation. Shared that she had dealt with some abuse and trauma. Reports some marijuana use in less than 30 days in the history of cocaine use 10 months ago. She denies any current issues or problem. Mood and affect somewhat anxious. Presents as intelligent, motivated and driven. Logical thought process, however, some difficulties with memory. (Respondent's Exhibit A page 164)

At Step 2, Petitioner has the burden of proof of establishing that she has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in the record that Petitioner suffers a severely restrictive physical or mental impairment. Petitioner has reports of pain in multiple areas of her body. However, there are no corresponding clinical findings that support the reports of symptoms and limitations to the level made by Petitioner. There are insufficient laboratory or x-ray findings listed in the file which support Petitioner's contention of disability. The clinical impression is that Petitioner is stable. There is no medical finding that Petitioner has any muscle atrophy or trauma, abnormality, or injury that is consistent with a deteriorating condition. In short, Petitioner has restricted herself from tasks associated with occupational functioning based upon her reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that Petitioner has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish that Petitioner has a severely restrictive physical impairment.

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living, social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work).... 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

There is insufficient objective medical/psychiatric evidence in the record indicating Petitioner suffers severe mental limitations. Petitioner was oriented to time, person and place during the hearing. Petitioner was able to answer all the questions at the hearing and was responsive to the questions. The evidentiary record is insufficient to find that Petitioner suffers a severely restrictive mental impairment. For these reasons, this Administrative Law Judge finds that Petitioner has failed to meet her burden of proof at Step 2. Petitioner must be denied benefits at this step based upon her failure to meet the evidentiary burden.

If Petitioner had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of Petitioner's condition does not give rise to a finding that she would meet a statutory listing in the code of federal regulations.

At Step 3, the medical evidence of Petitioner's condition does not give rise to a finding that Petitioner would meet a statutory listing in the code of federal regulations. This Administrative Law Judge finds that Petitioner's medical record does not support a finding that Petitioner's impairment(s) is a "listed impairment" or equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR Part 404, Part A.

If Petitioner had not already been denied at Step 2, this Administrative Law Judge would have to deny her again at Step 4 based upon her ability to perform her past relevant work. There is no evidence upon which this Administrative Law Judge could base a finding that Petitioner is unable to perform work in which she has been engaged in the past. Therefore, if Petitioner had not already been denied at Step 2, she would be denied again at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not Petitioner has the residual functional capacity to perform some other less strenuous tasks than in her prior jobs.

At Step 5, the burden of proof shifts to the Department to establish that Petitioner does not have residual functional capacity.

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated.... 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor... 20 CFR 416.967.

Sedentary work. 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. Although a sedentary job is defined as one which involves sitting, a certain amount of

walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Light work. 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 this 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).

Petitioner has submitted insufficient objective medical evidence that she lacks the residual functional capacity to perform some other less strenuous tasks than in her prior employment or that she is physically unable to do light or sedentary tasks if demanded of her. Petitioner's activities of daily living do not appear to be very limited and she should be able to perform light or sedentary work even with her impairments. Petitioner has failed to provide the necessary objective medical evidence to establish that she has a severe impairment or combination of impairments which prevent her from performing any level of work for a period of 12 months. Petitioner's testimony as to her limitations indicates that she should be able to perform light or sedentary work.

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent Petitioner from working at any job. Petitioner was able to answer all the questions at the hearing and was responsive to the questions. Petitioner was oriented to time, person and place during the hearing. Petitioner's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to Petitioner's ability to perform work. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that Petitioner has no residual functional capacity. Petitioner is disqualified from receiving disability at Step 5 based upon the fact that she has not established by objective medical evidence that she cannot perform light or sedentary work even with her impairments. Under the Medical-Vocational guidelines, an individual (age 54), with a high school education and an unskilled work history who is limited to light work, is not considered disabled.

Careful consideration has been given to Petitioner's allegations and symptoms. Petitioner has established that her mental condition could cause problems with daily and work functioning. However, the totality of the evidence does not support total disability. Petitioner's medically determinable impairments could reasonably be expected to produce alleged symptoms. Petitioner's statements concerning the intensity, persistence and limiting effects of these symptoms do not result in disability when compared to the limitations suggested by the objective medical evidence contained in the file.

It should be noted for the record that Petitioner continues to smoke, even though her doctor has told her to quit. Petitioner is not in compliance with her treatment program.

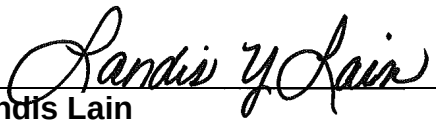
If an individual fails to follow prescribed treatment which would be expected to restore their ability to engage in substantial activity without good cause there will not be a finding of disability.... 20 CFR 416.994(b)(4)(iv).

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that Petitioner was not eligible to receive State Disability Assistance.

DECISION AND ORDER

The Administrative Law Judge, based upon the above Findings of Fact and Conclusions of Law, decides that the Department has appropriately established on the record that it was acting in compliance with department policy when it denied Petitioner's application for State Disability Assistance benefits based upon disability. Petitioner should be able to perform a wide range of light or sedentary work even with her impairments. The Department has established its case by a preponderance of the evidence.

Accordingly, the Department's decision is **AFFIRMED**



LL/hb

Landis Lain
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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

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

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

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

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

DHHS

Tamara Morris
125 E. Union St 7th Floor
Flint, MI 48502

Genesee County (Union), DHHS

BSC2 via electronic mail

L. Karadsheh via electronic mail

Petitioner

[redacted], MI [redacted]