[redacted]

Date Mailed: October 29, 2019
MOAHR Docket No.: 19-009080
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 September 30, 2019, from Detroit, Michigan. Petitioner appeared for the hearing with her mother, [redacted] and represented herself. The Department of Health and Human Services (Department) was represented by Kimberly Reed, Lead Worker and Elisa King, Eligibility Specialist.

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 [redacted], 2019, Petitioner submitted an application for cash assistance on the basis of a disability. (Exhibit A, pp. 142-157)

2. On or around June 6, 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. (Exhibit A, pp. 12-18)

3. On June 19, 2019, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled. (Exhibit A, pp. 7-10)

4. On August 20, 2019, Petitioner submitted a written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner alleged disabling impairments due to hepatitis C, cirrhosis of the liver, chronic kidney disease, and heart attack.

6. Petitioner initially confirmed that she did not allege any mental disabling impairments at the time of her SDA application; however, later in the hearing, Petitioner identified symptoms associated with post traumatic stress disorder (PTSD). Petitioner's mental impairments will not be addressed with this Hearing Decision, as they were not alleged at the time of application and not assessed by DDS.

7. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1972 date of birth; she was 5'5" and weighed 180 pounds.

8. Petitioner's highest level of education is 10th grade. She did not obtain a high school diploma or GED. Petitioner has reported employment history of work being a crew chief for a fire restoration company and a home health care aide. Petitioner reported that she has not had significant employment in several years but was unable to identify her last period of employment.

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, she 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 was thoroughly reviewed and is briefly summarized below.

On [redacted], 2019, Petitioner participated in a consultative physical internal medicine adult examination. Petitioner reported history of hepatitis C for which she was diagnosed five years ago, as well as cirrhosis diagnosed three years ago. Her current symptoms included nausea, malaise, and decreased appetite, as well as jaundice and gastric varices, as reviewed in a discharge summary from [redacted] 2019 which also included radiographic studies revealing cirrhosis, portal hypertension and hepatic encephalopathy. Records reviewed indicate that Petitioner was recently discharged from the hospital where she was receiving treatment for elevated ammonia levels with her last blood test being completed four days prior. Due to her medical issues, Petitioner indicated she felt her limitations are such that she cannot sit or stand longer than five minutes, cannot lift more than 20 or 30 pounds, cannot squat/arise from squatting, cannot climb more than five stairs, and cannot walk more than 100 feet. She reported that she uses a walker or a cane to assist with ambulation when she becomes

dizzy or has to walk distances; however, it is noted that she was not present with an assistive walking device to her examination. She needs to use a bathroom frequently when taking lactulose and has difficulty with foggy thinking. Physical examination of Petitioner's cardiovascular system indicated regular rate and rhythm with a grade II/VI systolic murmur heard throughout the precordium. S1 and S2 were physiologic. There was no S3 or S4 present. There were no rubs, clicks, heaves, snaps, or bruits noted. Peripheral pulses were present in equal in the upper extremities and dorsalis pedis arteries bilaterally. The lungs were clear to all stipulation in both anterior and posterior lung fields without evidence of rales or rhonchi. Petitioner's abdomen was diffusely tender, thus it was unable to properly assess for hepatosplenomegaly or masses palpable. There was no clubbing or cyanosis in the extremities. Petitioner's neurological exam indicated the following: she was alert and oriented times three, her mentation was intact although formal mental status exam was not performed, her manner affect and rest were appropriate, with cerebellar testing, namely finger to nose, this was performed with coarse tremors but without significant dysmetria or pronator drift. Her cranial nerves tested were grossly intact and motor strength testing was 5/5 in all muscle groups in the upper and lower extremities. Sensory examination was intact to light touch and deep tendon reflexes were 2/4 and symmetrical in the upper and lower extremities. She was able to ambulate under her own power and her gait was normal. Heel walking, toe walking, and tandem gait were normal. Romberg testing was normal. Examination of the cervical and dorsal lumbar spine revealed no paravertebral muscle spasm or gross abnormalities. The Medical Source Statement indicates that Petitioner denied chronic kidney disease but does have hepatitis C with cirrhosis, for which she has been recently hospitalized. She might have had renal involvement at some point in time and one might obtain older hospital records if needed. She will need to follow up with her doctors and take medications as directed, including lactulose. She will need close proximity to a bathroom when taking lactulose. She came to the examination without a walker or a cane and the doctor felt that she does not need to use these walking assistive devices unless she is fatigued and has to walk distances. She might avoid all alcohol and be encouraged to stop smoking. On examination that day, her blood pressure was elevated, and she was advised to follow up with her family doctor as well as to stop smoking. (Exhibit A, at pp. 39-45)

On [redacted], 2019, Petitioner presented to the emergency department of [redacted] with complaints of palpitations and shortness of breath. She reported that she fell in her bathtub 2 to 3 weeks ago and now has right-sided chest pain that has slowly worsened and is radiating into her substernal area. She was trying to sleep when she became short of breath, dizzy and was experiencing palpitations. She denied syncope but reported formal alcohol abuse, stating that she quit one year ago and only drinks on occasion now. Notes indicate that Petitioner was a somewhat difficult historian. At [redacted] emergency department, an EKG was performed revealing supraventricular tachycardia (SVT) and elevated troponin levels at 0.121 and 0.184. She was transferred to [redacted] for further evaluation and a cardiology consult. Cardiology consultation notes indicate that Petitioner was determined to be hemodynamically stable, without chest pain and results of the echocardiogram was pending, however it

was noted that an echocardiogram completed in 2015 showed an ejection fraction of 65%. Her troponin in setting of SVT was elevated and it was noted that the levels continued to increase. A possible left heart catheterization was being discussed, as she has history of aspirin allergy, cirrhosis, and thrombocytopenia. Encounter Notes further indicate that while Petitioner's EKG on arrival to the emergency department revealed SVT, after pharmacologic cardioversion an EKG revealed NSR without any acute ST or T-wave changes and it was determined that the SVT had resolved. Internal medicine history and physical notes from her evaluation indicated that Petitioner reported increased swelling in her legs and weight loss. She indicated that she is compliant with her medications, that she normally has 3 to 4 bowel movements daily with her lactulose and stated that she is being treated for hepatitis C but was unable to remember which medication she takes for it. Records indicate that Petitioner was diagnosed with and receiving treatment for hepatic encephalopathy, acute cystitis without hematuria, chest pain, non-ST elevated myocardial infarction (NSTEMI), cirrhosis, thrombocytopenia, SVT and anemia. Cardiovascular physical examination showed normal rate, regular rhythm and normal heart sounds. Examination revealed no gallop and no friction rub. No murmurs were heard. There was no lower extremity edema bilaterally and DP pulses 2+ bilaterally. Effort and breath sounds were normal, there was no respiratory distress, no wheezing, and no rales. Her abdomen was soft, bowel sounds normal, no distention and no tenderness or rebound were noted. There was normal range of motion to Petitioner's musculoskeletal system and she was alert and oriented to person, place, and time. There was normal neurological strength and no cranial nerve deficit or sensory deficit. Slight jaundice to the face was observed. On [redacted], 2019, a CTA of Petitioner's chest and a CT of her abdomen and pelvis were performed. Results of the CTA indicated that the pulmonary arteries in the lower lung zones were mildly degraded by respiratory motion artifact. Given this limitation, there was no evidence for pulmonary embolism. There was no acute process identified involving the trust, although mild cardiomegaly was noted, as were several old bilateral rib fractures. With respect to the abdomen and pelvis, there was no acute process involved, the abdominal aorta was normal in appearance with no evidence for aneurysm or dissection. The pancreas and spleen were normal in appearance and the spleen was normal in size. Several small areas of renal cortical scarring involving the right kidney were noted. The mesenteric arteries were patent and there was cirrhosis with portal hypertension, large para-esophageal varices and gastric varices in the gastric cardia region. A left heart catheterization was performed on [redacted], 2019 and showed normal coronary arteries and the left ventricle function wall motion were determined to be normal by echocardiogram. It was recommended that Petitioner receive physical therapy upon her discharge, as well as increased dose of metoprolol and atorvastatin. Notes indicate that while in the hospital, her level of function was independent the household distances on room air, that she has been using a two wheeled walker due to recent shortness of breath, that she was independent with bed mobility and transfers, had no loss of balance but was observed to have a slow pace, which Petitioner indicated requires UE support from a walker. It was noted that Petitioner may require a four wheeled walker with a seat to assist with ambulation. She was discharged on [redacted], 2019 and was to participate in home occupational therapy. (Exhibit A, pp.46 – 89)

Although Petitioner identified additional doctors or healthcare providers on the Medical – Social Questionnaire completed at the time of her SDA application, a review of Petitioner's case file and Exhibit A indicate that no additional medical evidence was received. Petitioner did not present any medical evidence to supplement or in addition to that admitted as Exhibit A.

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 1.02 (Major dysfunction of a joint(s) (due to any cause)), 5.05 (chronic liver disease) and 6.05 (chronic kidney disease), were considered. A thorough review of 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).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical conditions. Petitioner testified that she has been diagnosed with chronic kidney disease, liver disease, and cirrhosis. She testified that while she is not receiving dialysis, she has been placed on the kidney transplant list. She identified symptoms associated with her conditions including swelling, pain all over her body, shortness of breath, difficulty with balance and frequent bowel movements resulting from medication side effects. Petitioner testified that she can walk only to her mailbox and back due to

shortness of breath and that she uses a walker with a chair to assist with ambulation. Petitioner stated that she is able to sit for only 30 minutes and can lift up to 10 pounds. She reported that she can stand for only one minute, as her legs began to shoot pain throughout her body. She testified she is unable to bend, squat, or climb stairs and that she has lost her sense of balance and coordination. Petitioner reported difficulty with gripping or grasping items with both of her hands and testified that her hands cramp due to muscle related issues resulting from her kidney and liver impairments. Petitioner testified that she lives alone, that she is able to bathe herself and care for her own personal hygiene, but requires assistance getting in and out of the bathtub. Petitioner reported that she is able to dress herself but needs assistance with brushing her hair. She stated that she has a helper who comes to her home daily to assist with chores, cooking, and laundry. Petitioner does not drive and stated that she makes a grocery list and sends her helper to the store. She sometimes accompanies her helper to the grocery store but only if there is an electric cart available for her to use. The Department representative present for the hearing testified that she has been Petitioner's caseworker and has observed Petitioner struggle with pain and difficulty walking. It was noted that Petitioner had trouble speaking her thoughts and answering questions during the hearing.

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.

The evidence presented is considered to determine the consistency of Petitioner's statements regarding the intensity, persistence and limiting effects of her symptoms. Although reference to a wheeled walker was made in the medical evidence from Petitioner's [redacted] 2019 hospital treatment, Petitioner was not observed to require the assistive device during the consultative examination. No additional objective medical evidence or records documenting diagnostic testing or evaluation was presented for review. The records presented also do not show that Petitioner had any documented significant limitations with respect to her ability to sit, stand, carry or lift. Thus, as referenced above, although Petitioner has medically determinable impairments that could reasonably be expected to produce symptoms, Petitioner's statements about the intensity, persistence and limiting effects of her symptoms are not fully supported by the objective medical evidence presented for review and referenced in the above discussion.

Therefore, based on a thorough review of Petitioner's medical records and in consideration of the above referenced evidence, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(b).

Petitioner has additional nonexertional limitations with respect to performing manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. Based on the medical evidence presented, as well as Petitioner's testimony, it is found that Petitioner has mild to moderate limitations on her nonexertional 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 crew chief for a fire restoration company and a home health care aide. Upon review, Petitioner's past employment as a home health care aide is categorized as requiring medium exertion. Her past employment as a crew chief for the fire restoration company included job duties of dusting, cleaning, painting, climbing ladders, frequently lifting 25 to 100 or more pounds, walking/standing up to eight hours daily, as well as frequent stooping, kneeling, crouching and handling. Thus, it is categorized as requiring medium to heavy exertion. Based on the RFC analysis above, Petitioner's exertional RFC limits her to light work activities. As such, Petitioner is incapable of performing past relevant work. Because Petitioner is unable to perform past relevant work, she 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, 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 [redacted] years old at the time of application and at the time of hearing, and thus, considered to be a younger individual (age [redacted]) for purposes of Appendix 2. She is not a high school graduate and thus, has limited or less education level but is able to read and write and communicate in English. Petitioner has unskilled to semi-skilled work history that is not transferable. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines result in a finding that Petitioner is not disabled.

Additionally, Petitioner has a nonexertional RFC imposing only mild to moderate limitations on her non-exertional ability to perform basic work activities with respect to performing manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. Based on the evidence presented, at this time, it is found that the limitations identified would not preclude Petitioner 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.**

ZB/tm

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

DHHS

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Petitioner

[redacted]

cc: SDA: L. Karadsheh
AP Specialist Montcalm County (3)