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Date Mailed: December 11, 2019
MOAHR Docket No.: 19-010732
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on November 18, 2019, from [redacted] Michigan. The Petitioner was represented by himself. The Department of Health and Human Services (Department) was represented by Renee Jones, Eligibility Specialist.

The record closed on November 18, 2019, at the conclusion of the hearing; and the matter is before the undersigned for a final determination based on the evidence presented.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit programs?

FINDINGS OF FACT

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

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

2. On October 7, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 8-14).

3. On October 8, 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. 5-7).

4. On October 8, 2019, the Department received Petitioner's timely written request for hearing (Exhibit A, pp. 3-4).

5. Petitioner alleged physical impairments including headaches, back pain on the left in the thoracic spine, neck and back of the head due to an assault a year ago, and high blood pressure. The Petitioner also has fatigue with a heart stent and heart problems with dizziness. Petitioner alleged disabling impairment due to mental impairment due to depression and anger issues with problems with people being able to understand Petitioner.

6. On the date of the hearing, Petitioner was [redacted] years old with a [redacted] birth date; he is [redacted] in height and weighs about [redacted] pounds.

7. Petitioner completed the [redacted] grade.

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

9. Petitioner has an employment history of work as a janitor cleaning bathrooms and has not worked for 10 to 15 years.

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 1

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 2

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimis* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience*. Higgs v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988)*, citing Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process*. Id.;* SSR 96-3p.

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

The Petitioner participated in a psychological consultative examination on [redacted] 2019. At the exam, Petitioner presented with depression due to recent death of his mother and difficulty being around people who he stated do not understand him. During the mental status exam, Petitioner complained of seeing God and the devil while sleeping, but denied alcohol abuse, anxiety, disturbances of consciousness, disturbances of emotion, memory, thinking, drug abuse, eating disorder, insomnia, mania, paranoia, psychosis and suicidality. Petitioner exhibited no psychomotor activity but was slow; his mood was suspicious and evasive with no eye contact. Petitioner was able to recall five (5) digits, repeat numbers backwards, three (3) digits, with thought overall as normal form and content. Memory noted normal with recollection of past events, was able to recall recent news events, was able to recall last three meals and able to recall three of five words after five (5) minutes. The Petitioner was estimated with Low Average Intellectual Functioning. Judgement and insight were intact. At the conclusion of the

exam, the diagnosis was Major Depressive Disorder recurrent, unspecified. The examiner concluded the following: Petitioner's ability to understand, remember, and apply information: mild limitations; concentration, persistence, and pace: mild limitations; social interaction: mild limitations; adaptation and self-management: mild limitations. The notes further conclude the Petitioner is able to manage his funds.

The Petitioner was also physically examined during a consultative examination also conducted on [redacted] 2019. During the exam, the doctor noted that the flexion, extension, right lateral flexion, left lateral flexion, right rotation and left rotation were painful with movement with had full range of motion in the cervical spine. The remainder, the physical examination noted that the cervical, lumbar, shoulders, elbows hips, knees and ankles all had normal range of motion. It is also noted that with respect to the evaluation of hands and fingers, all flexion and extension were normal. Straight-leg-raising test was also conducted and was normal. The Petitioner was able to walk on his heels and toes, tandem walk; and his gait was stable and within normal limits. The doctor concluded that a need for walking aid was not supported by the clinical evidence. Grip strength for each hand was 5:5. The doctor noted no neurologic or orthopedic inability to sit, stand, bend, stoop, carry, push, pull, button clothes, tie shoes, dress/undress, open a door, make a fist, pick up a coin, pick up a pencil, write, squat and arise from squatting, get on and off the exam table, and climb stairs. All his reflexes in both upper and lower extremities were normal. The examiner's notes indicate that Petitioner denied headaches, memory loss and complained of hypertension. During the examination, his respiratory effort/rhythm overall was non-labored and normal. The notes indicate Petitioner's cervical spine was tender with full range of motion for his right and left upper extremities. The notes indicate some crepitus in the left knee. The assessment and plan were essential hypertension, mixed hyperlipidemia and major depressive disorder recurrent unspecified. The medical source statement states the patient presents for disability assessment and has moderate pain frequently of the neck with range of motion. No limitations noted during the exam. The patient's blood pressure is uncontrolled, and the patient was advised to go to the emergency room right away. Petitioner's blood pressure was taken twice during the examination; the first time was tested at 200/120; the second attempt was 190/110.

The Petitioner has participated in an outpatient treatment for depression. On [redacted] 2019, the Petitioner was seen by his therapist and presented with current mood stability with reports of no new stressors at the time of the exam. The assessment was moderate recurrent major depression due to death of a family member. The notes indicate some medication noncompliance but is otherwise nonspecific, and the notes further indicate malignant hypertension. The therapist noted that Petitioner has been doing fine, and medication has been helping; mood is better; and sleep and energy are fine. Sleep and appetite are also fine. The Petitioner was also examined by a nurse practitioner associated with his psychiatric treatment clinic on [redacted] 2019. During the examination, the Petitioner reported no chest pain or palpitations, no dips; knee blood pressure was 157/104 and also 168/103. The Petitioner's heart rate and rhythm were

normal, and his mood was described as euthymic. The Petitioner's PSA was 5.6 and was referred for a consult with urology. The Petitioner was to follow up for both his blood pressure check and hyperlipidemia in one month. The Examination of Petitioner's neck noted suppleness with no demonstration or decrease. On [redacted] 2019, the Petitioner was seen for a blood pressure check at the clinic. Petitioner stated he ran out of his medication over a month ago. During this exam, he was diagnosed with malignant hypertension and was sent to the emergency room (ER). During the check, his blood pressure measured 203/118 and 206/119.

A thorough review of all of the therapy sessions indicate Petitioner is able to appear engaged and cooperative in the sessions and has had a good response to Wellbutrin with reports of normal sleep, energy and appetite. Petitioner's mood is described as stable, and he is cooperative and doing fine for the most recent records covering the period [redacted] 2019 through [redacted] 2019. At his initial clinical behavioral health assessment, Petitioner presented with a somber mood, good grooming, with good eye contact and reported excessive sleeping, tiredness, trouble concentrating and feeling bad about himself. At the time of the intake, Petitioner was not taking psychotropic medications. During the exam, Petitioner reported daily use of marijuana, one time a day and alcohol once a week.

The Petitioner was seen at the emergency room on [redacted] 2019, being sent there by his primary care physician due to his elevated blood pressure. The history given by Petitioner reports that he's been out of his blood pressure medication for the last week and is unable to recall the names or doses. Patient describes that he recently lost his mother and says he has been under increasing amounts of stress and has not taken his medication. He denied any shortness of breath, chest pain or palpitations. The emergency room medical decision indicated that without symptoms, a hypertensive emergency was not suggested. His medications for carvedilol and lisinopril were refilled. The Petitioner was advised to follow up with his primary care physician and was stable for discharge.

The Petitioner was seen as a new patient by a cardiologist on [redacted] 2019, with complaints of dyspnea. The Petitioner was seen due to an abnormal EKG during his last primary care doctor's visit. During the exam, Petitioner reported intermittent chest pains and heaviness associated with shortness of breath for approximately one month. An EKG was performed during the examination and noted severe LVH with ST depression in the inferior leads. The Assessment was the Patient was asymptomatic with a severe left ventricular hypertrophy, and the doctor recommended a stress echocardiogram be performed to evaluate coronary ischemia/coronary artery disease. The notes also indicate that his hypertension was uncontrolled and that Petitioner does not take his prescribed antihypertensive medications. A low-salt diet was also recommended. The doctor strongly recommended smoking cessation to reduce further insult to the coronary vascular system.

The Petitioner was seen in the Ascension - St. John emergency room on [redacted] 2019, and was diagnosed with hypertension and major depressive disorder and was prescribed Lisinopril and Zoloft. At the time of his arrival, the Petitioner presented with complaints of depression. Petitioner admitted to sleeping more, increased fatigue, weight loss, decrease in appetite, difficulty with concentrating. Petitioner was not in treatment/psychotherapy or under the care of a psychiatrist or on any medications. During his physical exam, the Petitioner was well-oriented, his heart was normal. At the time of his presentation, Petitioner was asymptomatic, but with clearly uncontrolled hypertension. After an EKG was obtained, it demonstrated concerning T-wave changes in the V1-V6 and troponin testing was ordered to assess ischemia. The Petitioner was administered blood pressure medication with improvement in the blood pressure to 175 systolic and remained asymptomatic. The Petitioner, due to his uncontrolled hypertension with signs and an EKG of left ventricular hyper trophy and biphasic T-wave's in lateral leads, raised concern for lateral ischemia and need for a cardiology evaluation. The Petitioner was placed in the cardiology area for observation. After a two-day stay, the re-examination noted Patient was in no distress with no shortness of breath, chest pain and denying any suicidal or homicidal ideation. Vital signs were stable except for still having elevated blood pressure. After a cardiology evaluation, the department felt he could be discharged home and continue with Lisinopril. After being examined by psychiatry, Zoloft was recommended; but the need for inpatient treatment was not recommended. The echocardiogram indicated a diminished ejection fraction of 20 percent. Cardiology was again consulted and stated the Petitioner did not need a cardiac catheterization; but with added medication, she would follow up with the Patient in an office visit. The final impression was congestive heart failure, new onset, hypertension uncontrolled history of noncompliance, major depression, essential hypertension and major depressive disorder single episode unspecified.

The Petitioner had a transthoracic echocardiogram on [redacted] 2019. The study conclusions note the left ventricle cavity size is normal, with wall thicknesses mildly increased. Systolic function is severely reduced. The estimated ejection fraction is 20 to 25 percent severe global hypokinesis grade 1-LV diastolic impairment. Right ventricle was normal, and systolic function normal. The mitral valve was normal in structure and motion with mild regurgitation. The aortic valve was normal in structure and motion with normal thickness leaflets with normal cusps separation with no stenosis and no significant regurgitation. The tricuspid valve noted mild regurgitation.

Petitioner was also seen at Team Mental Health's mental health care provider by his care coordinator. His care worker assisted Petitioner with completing forms for the department and Social Security with regard to his applications for disability. On [redacted] 2019, Petitioner was seen by his therapist who noted Petitioner displays a calm mood and is tearful throughout the session with normal speech, intact judgment and average intellectual functioning and is dressed appropriately for the weather.

On [redacted] 2019, the Petitioner was seen; and the notes indicate he presented with depressed mood and constricted affect with average intellectual functioning; and notes

indicate further that member had an odor to him. During this session, a crisis plan was discussed identifying triggers to crisis and healthy coping skills to avoid crisis. The Petitioner had an integrated biopsychosocial assessment on [redacted] 2019, at which time notes indicate he was a new patient and was seeking treatment due to a series of stressful events. At that time, he reported sleeping 12 to 16 hours a day and was losing weight without a change in appetite. Petitioner self-reported having sought inpatient mental health treatment three times and has received outpatient mental health treatment in three different community mental health facilities. The Petitioner was not suicidal and expressed symptoms of sadness, depression, low energy, anger/irritability, anxiety, worry, fatigue and reported being homeless at the time of the interview. The Petitioner's judgment was evaluated as fair, and his insight was noted as insightful. This mental health care provider was new in [redacted] 2019.

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 3

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 4.02 chronic heart failure and 12.04 Depressive, bipolar and related 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). In addition, four broad functional areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself) are considered when determining an individual's degree of mental functional limitation. 20 CFR 416.920a(c)(3). The degree of limitation for the first three functional areas is rated by a five-point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4). A four-point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

In this case, Petitioner alleges both exertional and nonexertional limitations due to his medical condition. Petitioner testified that he could stand 30 minutes to an hour but would need a break. He could walk two blocks and would need to rest. He could squat with noise in his joints. He could bend only 70 percent forward. He can shower and dress himself, tie his shoes and touch his toes. He could carry between 5 and 10 pounds. Petitioner also testified that he has fatigue and sleeps 12 to 16 hours daily and has dizziness due to his heart problem.

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

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner maintains the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

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. Although Petitioner presented with severe symptoms, it appears that with medication his depression improved. He continues to treat with a therapist. The consultative examination noted only mild limitations in his abilities as set forth in Step 2 of this Decision- Conclusions of Law.

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step 4

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 janitor cleaning lavatories which he performed 10 to 15 years ago. Petitioner's work as a janitor required standing much of the work shift. Petitioner could not recall the extent or weight of the lifting requirements. The janitorial job required light physical exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than sedentary work activities. As such, Petitioner is incapable of performing past relevant work. In light of the entire record, it is found that Petitioner's exertional RFC prohibits him from performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues to Step 5.

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services*, 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v Campbell*, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

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 [redacted] years old at the time of hearing, and thus, considered to be advanced age (age 55 and over) closely approaching retirement age (60-64) for purposes of Appendix 2. He completed the 9th grade with a work history of work experience as a janitor. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

In this case, the Medical-Vocational Guidelines, Rule 201.09 results in a disability finding based on Petitioner's exertional limitations.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

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

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's [redacted], 2019 SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

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

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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

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

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

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

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

DHHS
(via electronic mail)

Dora Allen
MDHHS-[redacted]-Hearings
BSC4
L Karadsheh

Petitioner
(via first class mail)

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