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Date Mailed: January 17, 2020
MOAHR Docket No.: 19-011473
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 Kael Meyers, Assistance Payments Supervisor, and Brenda Prentice, Eligibility Specialist.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. In addition, the Department provided three exhibits: Exhibit A, Exhibit B and Exhibit C, which were not provided with the hearing packet but were determined to be part of the medical evidence which should have been provided with the hearing packet. Exhibit B, consisting of 135 pages (unnumbered); Exhibit C consisting of 165 pages (unnumbered) and Exhibit D consisting of 195 (unnumbered) were received and marked into evidence. The medical record requested form [redacted] for the six months preceding the hearing were no received as the provider said no medical records or tests were available as Petitioner had not been seen during the six-month period. The record closed on December 19, 2019, and the matter is now 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 July 3, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On September 24, 2019, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.

3. On September 30, 2019, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On October 15, 2019, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to neck, lumbar.

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 9th grade, attended special education classes while in school and also has a GED.

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

9. Petitioner has no substantial gainful employment history.

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 is summarized below.

It should be noted that Exhibit B and Exhibit C and part of Exhibit D, which were sent to the undersigned after the hearing, contain older medical records from 2008 through 2011 and contain some current medical information regarding Petitioner's condition.

On [redacted] 2019, the Petitioner received an onsite consult with records indicating last risk assessments were performed in [redacted] 2018 through [redacted] 2017 and indicated that no risk of suicide or homicide were present. At the time of the onsite consult, the Petitioner indicated that he was not interested in behavioral health services. Petitioner was seeking assistance regarding his medical issues. The behavioral health diagnosis was adjustment disorder with depressed mood of moderate severity. The Petitioner presented with complaints of shoulder pain with a diagnosis of incomplete tear of right rotator cuff with physical therapy to help strengthen the shoulder and a consult with an orthopedic surgeon for surgery evaluation or possible steroid injections. No referral to a pain specialist was made until surgery evaluated and physical therapy course. Petitioner also complained of low libido and a possible testicular mass. Petitioner was to be tested for testosterone levels and an ultrasound of testicle. Notes indicate that the condition was not likely a mass. The notes indicate that symptoms for right shoulder include numbness and tingling in the arms. An MRI showed a partial shoulder tear, and Petitioner did not go to the orthopedic referral as he is afraid of surgery. The MRI was not provided or included. Petitioner presented with flat affect and depressed mood. Notes indicate 10th grade education with GED and has special needs due to learning disability in multiple areas. Notes also indicate normal full AROM of right shoulder.

The medical records also contained a DDS ordered psychological Medical Report dated [redacted] 2017. During this exam, the Petitioner was not on medications for his mental health and depression and had seen a therapist 4 or 5 times. He also stated he was hearing voices again recently which also caused him depression. Petitioner reported to the examiner that he is a registered sex offender. Petitioner reported that he likes to watch television. Petitioner was not working due to back, neck and shoulder pain. When asked what he did yesterday, he said he could not remember. The Petitioner reported that his appetite comes and goes, and he sometimes does not eat and sleeps about 4 hours in a 24-hour period. Petitioner reported that he does most of his own cooking, cleaning laundry and shopping. He also described having things on his mind when trying to sleep causing difficulty with sleeping. Petitioner also reported two in-patient stays due to mental health. At the conclusion of the exam, the diagnosis was Major Depressive Disorder and alcohol use disorder. The prognosis was guarded – poor. The evaluator found Petitioner was unable to manage his benefit funds. An earlier evaluation in 2011 concluded a poor prognosis and that it was unlikely and the chances were poor that Petitioner could become gainfully employed and also noted borderline intellectual functioning based upon intelligence testing. He tested extremely low on the Wechsler Adult Intelligence Test.

The Interim Order issued in this case sought records from [redacted] for the last six months. The provider responded that Petitioner had not been seen by the practice since [redacted] 2019; and thus, there were no medical records to be provided.

At the time of the completion of the Medical Social Questionnaire in this case, the intake specialist noted indication of learning disability and depression with note that Petitioner had difficulty understanding.

On [redacted] 2019, the Petitioner participated in a Psychiatric/psychological examination scheduled by the DDS. The conclusion by the examiner gave diagnoses of Major Depressive Disorder-Recurrent with Psychosis, rule out Borderline Intelligence, chronic back and shoulder pain, with a GAF of 55. Prognosis was poor, and Petitioner was evaluated as unable to manage his benefit funds. A review of the report notes indicate the following: Mental Status description of attitude/behavior: self-esteem was low, symptoms were not exaggerated, insight was poor; Stream of mental activity: poor speech articulation, slow speech, stream of thought content not well organized, judgment poor, concentration poor; Mental trend/thought content: hallucinations (voices) couple times a week, worthlessness expressed, no suicidal intention; Emotional reactions: depressed. The mental capacity evaluation found Petitioner did not know the date and could not recall three objects after three minutes, could not recall when he earned a GED, did not name five large cities, could name three presidents, could not perform division or some multiplication. Abstract thinking notes indicate the Petitioner was in special education and completed 9th grade. The Petitioner articulated that "I don't' like to go nowhere," and that he did not like taking medications and the best way for him to deal with his depression is to not be around people. He further stated he gets angry easily such as when someone asking him for money or calling him about his son. He reported being in prison for 11 years and has not worked since 2011 working on a farm for about one and a half months. Petitioner also describe that when mad, he does not eat and has difficulty sleeping. Petitioner reported two psychiatric hospitalizations in 1999 for a month and a second time for several months. Petitioner was not in treatment for behavioral health. Petitioner reported he did not have friends and stays away from his family and his neighbors and reported problems with supervisors and co-workers.

The Petitioner participated in a consultative physical examination on [redacted] 2019. During the examination, the Petitioner reported pain in his back, neck and shoulders for the past 10 years. The Petitioner reported he has had several car accidents and went through the windshield one time and was thrown out of the vehicle another time. The Petitioner also reported receiving injections in his shoulder in the past that helped somewhat. The Petitioner uses a cane sometimes when his pain is at its worst. Petitioner reports difficulty with bending, stretching and sometimes almost falling in the shower due to discomfort. He cannot sit very long or stand for very long or walk very far. When asked to quantify this, he was not able to give the examiner a number on a scale when he experiences pain. On a good day, pain level is 4/10; and at the exam, pain reported as 6/10. Pain worsens with bending over, lifting, squatting and medications sometimes. Petitioner also reported that his left shoulder was "broken," but he declined surgery because he is fearful. The examiner did not have any medical records demonstrating any imaging to review. The only record available was a primary care visit regarding a testicular mass with a secondary diagnosis of shoulder pain that is intermittent and was stable regarding the right shoulder on [redacted] 2019. The

neurologic examination was essentially normal except for a positive Babinski sign, which was positive plantar bilaterally. Straight leg raising test was negative both seated and supine position. The examiner found patient able to sit, stand, bend, stoop, carry, push, pull, button clothes, tie shoes, dress and undress, dial a phone, open a door and make a fist, pick up a coin and pencil, squat down and get back up, and get on and off the exam table. The Petitioner was positive for paraspinal muscle spasm over the lumbar spine with decreased range of motion of the lumbar spine with painful movement. The Petitioner stated there was pain with decreased range of motion at the values listed in the report for the bilateral shoulders diminished on both right and left sides and did not proceed with testing due shoulder pain. The examiner concluded that the Petitioner presented with musculoskeletal complaints with vague diagnoses. The Examiner merely stated that Petitioner believes he has degenerative disc disease and a torn muscle in the right shoulder and possible break in the left based on what he had been told by doctors who examined him and has declined surgery in the past. The examiner concluded the Petitioner would benefit from follow-up with primary care regarding musculoskeletal complaints with possible physical therapy to enhance quality of life.

The medical evidence presented contains a consistent history, although not current of complaints of shoulder and back pain and ongoing mental health issues with depression and severe learning disability with low intellectual functioning. Also contained in the previously filed medical social questionnaire completed in 2012 notes indicate that he could work for approximately two days but couldn't really understand what the employer [redacted] wanted him to do. See for example Exhibit D. All of his radiographic evidence regarding his lumbar and cervical spine and shoulder are from old x-rays from 2008 noting mild degenerative disc disease with endplate spurring at C5-C6 for the cervical spine; and an unremarkable lumbar spine x-ray. Petitioner was previously approved by the Medical Review Team based on a psychiatric exam in 2010.

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 *1.04* Disorders of the spine, 1.02 Major dysfunction of a joint(s) (due to any cause) and 12.04 Depressive, bipolar and related disorders and 12.05 Intellectual disorder 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 conditions. Petitioner testified that he avoids people and shops quickly so he does not have to be around other individuals and also has no hobbies or things he likes to do. He has limited reading ability and does not read much due to concentration issues. Petitioner testified that he could stand a couple of hours and can sit 20 minutes or less, walk a block and can perform a squat and bend at the waist with pain, as well as experiences pain when reaching for clothes or other things. Petitioner can shower and dress himself and tie his shoes but has pain touching his toes. He could carry at least 7 pounds with his left hand or arm and less with his right hand or arm due to shoulder pain and evidence of a partial pre-existing shoulder tear. He also testified that his right hand is numb. With respect to his depression, Petitioner credibly testified that he has difficulty sleeping, sometimes does not sleep due to pain and his thoughts keeping him up. His appetite is also affected by pain and sometimes he does not eat. Petitioner has also had an injection in his shoulder. Petitioner testified that he gets headaches when mad or depressed. Petitioner also testified he has limited transportation and becomes frustrated with mental health services trying to get there. He has not been seeing his primary care doctors due to depression and inability to get transportation there. Petitioner testified that his depression causes him to avoid contact

with others, he has no friends and does not see his family. He expressed becoming angry and did not know or understand why. He also expressed that he needs help staying calm, which is why he avoids others. His memory is weak and becomes worse when he is upset. Petitioner is not married, lives alone and expressed that he becomes angry when around his children.

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

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

Based on the historical medical record presented, the Consultative exam which found his prognosis poor, the failure to have Petitioner's intellectual deficits tested as suggested by the Psychiatric/Psychological examiner's diagnosis "rule out Borderline Intelligence, himself as well as Petitioner's testimony, Petitioner has moderate-to-severe limitations on his mental ability to perform basic work activities set forth as follows based upon his most recent Psychiatric/Psychological evaluation: the Petitioner's ability to understand, remember or apply information markedly limited, his ability to interact with others is markedly limited; Petitioner's ability to concentrate, persist or maintain pace is markedly limited and his ability to adapt or manage himself is moderately limited as he avoids others rated as a 3 on a scale of 1 to 5.

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 a short work experience at [redacted] of very short duration, and Petitioner reported he did not understand what the employer wanted and thus, is not considered relevant work

Based on the RFC analysis above, Petitioner's exertional RFC limits him to no more than light work activities; however, the Petitioner has no past relevant work to be evaluated. Petitioner also has several marked limitations in his mental capacity and ability to perform basic work activities. The analysis continues to Step 5 as there are no past work activities to make a determination regarding Petitioner's ability to perform past relevant work.

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 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 a younger individual (age 45-49) for purposes of Appendix 2. He attended high school through the 9th grade with special education classes since grade school, has a history of severe learning disabilities based on historical testing and has a GED with no past relevant work. 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.

Based solely on his exertional RFC, the Medical-Vocational Guidelines, Rule 202.17, result in a finding that Petitioner is not disabled.

Petitioner's nonexertional RFC imposing moderate to marked limitations on his mental ability and evidence of below average intellectual functioning does not support a finding that Petitioner is able to perform basic work activities and thus it is determined that he is precluded from being able to adjust to other work. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which

Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is 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 **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 January 2021.

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

Kael Meyer
MDHHS-[redacted]Hearings
L Karadsheh
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Petitioner

Anthony Rollins
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