[redacted]

Date Mailed: April 8, 2020
MOAHR Docket No.: 20-000868
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 March 12, 2020, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Lacy Miller, Hearing Coordinator.

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. 4-17)

2. On or around January 13, 2020, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 886-912)

3. On January 17, 2020, 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. 918-921)

4. On January 27, 2020, Petitioner submitted a written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, pp. 923-924)

5. Petitioner alleged mainly mentally disabling impairments due to Post-Traumatic Stress Disorder (PTSD), depression, anxiety, and Stockholm syndrome.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1962 date of birth; she was 5'4" and weighed 140 pounds.

7. Petitioner completed obtained a juris doctor law degree 20 years ago but has not been employed as a lawyer, as her husband was responsible for the household income. Petitioner reported her only past employment in the last 15 years was as a stocker at [redacted]. Petitioner has not been employed since 2008.

8. 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 under Step 1, and the analysis continues to Step 2.

Step Two

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

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

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

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below.

[redacted] of [redacted] submitted a letter on Petitioner's behalf documenting the course of Petitioner's individual psychotherapy treatment for major depressive disorder recurrent and PTSD from 1988 through 1999. The letter indicates that Petitioner was receiving treatment due to various emotional, physical, and sexual abuse occurrences throughout her lifetime, including a rape in 1986. Petitioner was referred to psychiatric treatment and medication services in 1995. The letter further indicates that Petitioner suffered isolation, intimidation, physical violence and broken bones as a result of the victimization and abuse during her marriage. [redacted] also indicated that Petitioner had not worked outside of the home, as she was not allowed to have a cell phone or drive and that the final straw that ended the 20 year cycle of victimization was when Petitioner's husband was convicted of sexually abusing her [redacted]-year-old granddaughter and sentenced to prison. [redacted] was of the opinion that Petitioner suffered from classic Stockholm syndrome where Petitioner blamed the abuser's offenses on herself. Petitioner's diagnosis has remained the same except now it is more severe, and her conditions limit her from being a candidate for work in any capacity. (Exhibit A, pp.99 – 102)

A letter authored by [redacted] of [redacted] indicates that Petitioner has been receiving treatment with him on a regular basis since January 2019 for her PTSD and generalized anxiety disorder. (Exhibit A, p.22)

Petitioner's records from her treatment with [redacted] and [redacted] were presented and reviewed. During an initial psychiatric evaluation in [redacted] 2019, Petitioner reported that she has been under extreme stress as her husband was arrested for molesting their granddaughters in [redacted]. Petitioner reported a history of

PTSD from being abducted, strangled, and raped by four men, as well as suffering from abuse at the hands of hands of her first husband. Petitioner reported developing agoraphobia since her grandson died in 2009 of Mosaic Down syndrome, as well as due to her attacker being released from prison. She reported a history of multiple head injuries resulting from assaults and concussions as a child but did not report having suffered any seizures. She was taking prescribed medications including Xanax and Zoloft. Records indicate that Petitioner's psychiatric symptoms started at age [redacted], that she was previously receiving outpatient treatment with [redacted] and that she was previously hospitalized inpatient due to a suicide attempt in 1986. She reported a family history of mental illness and admitted to having a history of physical, emotional, and sexual abuse. Upon mental status examination, Petitioner's mood was depressed/irritable, and her concentration, insight, and judgment were fair. Petitioner was diagnosed with PTSD, generalized anxiety disorder, agoraphobia with panic disorder and depression. Trazodone was added to her prescribed medications and she was referred to a therapist for therapy sessions. Petitioner presented for a follow-up in [redacted] 2019 during which she indicated she is struggling with motivation and suffering from nightmares for which she was prescribed clonidine in addition to her other psychotropic medications. In [redacted] 2019, Petitioner reported that her sleep has been problematic which continued into [redacted] 2019 along with continuous fatigue. During her [redacted], 2019 appointment, Petitioner was very anxious and stressed due to her ex-husband being in jail and her grandchildren visiting which made her sad about the abuse that happened to them, reporting that she does not leave her house. She reported that her sleep is poor and that she has stopped taking the trazodone due to being informed that she was diagnosed with a heart condition. Her medication was changed, and she was prescribed Seroquel. In [redacted] 2019, Petitioner indicated that she had stress about whether to make an impact statement at her ex-husband's sentencing for his criminal conviction of sexual abuse to her grandchildren. She reported side effects of her medications including grogginess. (Exhibit A, pp. 139 -164)

Petitioner was receiving treatment and managed care for her major depression and PTSD at [redacted]. (Exhibit Ap.84) During a [redacted], 2018 appointment, Petitioner reported that her ex-husband was arrested for molesting their 11-year-old granddaughter and she now has a PPO against him. She was financially dependent on her husband and had not worked in 20 years due to her depression and PTSD. She has difficulty working in fast-paced crowded places, is socially withdrawn, rarely leaves her house and has difficulty keeping focused. Petitioner reported that in 1986, she was abducted, beat and raped by a gang of men, one of whom was recently released from prison, which makes her more depressed and anxious. She also has a PPO against her attacker. In 1986 and 1987, she had two suicide attempts. She suffers from difficulty sleeping and nightmares due to a history of abuse dating back to age 16 when her mother let her marry a 19-year-old man who beat her and damage her nose eventually requiring a rhinoplasty. She has since divorced that man and it was reported that her second husband molested her daughter and the third husband was convicted of sexual abuse to her grandchildren. She indicated that the medication dosage was not enough to contain her anxiety. Records show that she was diagnosed and receiving

treatment for major depression, generalized anxiety disorder, insomnia and PTSD, among other physical conditions. (Exhibit A, pp.45 – 48, -171-206)

Petitioner was also receiving treatment at [redacted]. In [redacted] 2018, Petitioner was being evaluated for significant coronary artery disease, as abnormalities were seen on an ECG testing. An echocardiogram and stress test were scheduled, as was a 24-hour Holter monitor study, to better clarify if significant supraventricular or ventricular arrhythmias were contributing to Petitioner's symptoms. A stress test completed in [redacted] 2019 showed a left ventricular ejection fraction of 58% and areas of inferno septal and apical perfusion defects of uncertain significance. A diagnostic cardiac catheterization was recommended to precisely define the coronary artery anatomy and define continued treatment. The results of the catheterization showed normal left ventricular function without significant coronary disease. Petitioner was to be treated with current medication regimen and follow-up with cardiology. (Exhibit A, pp. 115-133)

Extensive treatment records from Petitioner's visits at [redacted] and [redacted] were reviewed and reflect similar findings to those summarized above.

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 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive-compulsive disorders), and 12.15 (trauma-and stressor-related disorders) were considered. were considered. The medical evidence presented does not show that Petitioner has physical or exertional impairments that meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. However, Petitioner's record reflects a history of physical, emotional and sexual abuse dating back to age 16 which has resulted in agoraphobia, immobilizing flashbacks, frequent nightmares, and panic attacks when out in public places and fear of her attacker who was released from prison. Petitioner's record further indicates that she suffers from

suicidal ideations, practices her noose tying, and has symptoms of depression, anxiety/panic disorder, agoraphobia and PTSD characterized by depressed mood, diminished interest in activities, sleep disturbances, thoughts of death/suicide, difficulty concentrating, irritability, and panic attacks that she will be attacked. Upon thorough review, and in consideration of Petitioner's presentation during the hearing, as well as the above referenced medical documentation of her mental impairments, were sufficient to establish that, when combined, the impairments meet or are equal to the required level in severity to the criteria in Appendix 1 of the Guidelines to be considered as disabled. Accordingly, Petitioner **is disabled** at Step 3 and no further analysis is required.

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 SDA 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; and

3. Review Petitioner's continued eligibility in February 2021.

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

Erin Bancroft
105 W. Tolles Drive
St. Johns, MI
48879

Petitioner

[redacted]

cc: SDA: L. Karadsheh
AP Specialist-Clinton County (2)