[redacted]

Date Mailed: April 8, 2020
MOAHR Docket No.: 20-000916
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 himself. The Department of Health and Human Services (Department) was represented by Valarie Foley, Hearing Facilitator.

The Department's Exhibit A, pp. 1-124 and Petitioner's Exhibit 1, pp. 1-114 were admitted into the record as evidence. Petitioner indicated that there may be medical evidence missing from the admitted exhibits. Petitioner could not identify what medical evidence was not included in the documents admitted into record as Exhibit A and Exhibit 1 and after some review of the documents, indicated that the undersigned was in possession of his complete records and medical documentation. Petitioner also did not indicate that he had additional medical evidence to present, therefore, an interim order extending the record in order to obtain additional medical evidence was not issued.

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 seeking cash assistance benefits on the basis of a disability.

2. On or around January 22, 2020, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 81-88)

3. On or around January 24, 2020, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 120-124)

4. On January 31, 2020, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of his SDA application. (Exhibit A, pp. 3-4)

5. Petitioner alleged disabling impairments due to low back pain, cervical pain, joint pain in the neck, back, shoulders, hips, knees, ankles, feet and hands, as well as, inflammatory arthritis. Although not reflected on the Medical Social Questionnaire completed at the time of the SDA application, during the hearing, Petitioner also alleged he has a skin condition, abdominal pain, difficulty breathing due to COPD and a collapsed lung. There was no evidence that Petitioner alleged any mental disabling impairments.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1986 date of birth; he was 5'11" and weighed 145 pounds.

7. Petitioner obtained a Bachelor of Business degree in accounting and has reported employment history of work as a professional chauffeur, a security officer, an armored vehicle driver, as a supply chain manager, a bill of materials analyst, a production manager, a financial analyst, and an inventory analyst. Petitioner has reportedly not been employed since July 2019. (Exhibit A, pp. 61, 73-79)

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, he 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.

Records from Petitioner's treatment with rheumatologist [redacted] were presented and reviewed. (Exhibit A, pp. 37-52). On [redacted], 2020, Petitioner presented for evaluation of chronic low back pain and cervicalgia arthralgias. It was noted that Petitioner was a poor historian who was unable to recall facts or when his issues started. While Petitioner insisted that he had a positive ANA test in the past, the doctor reviewed the records and lab studies in [redacted], which were all negative. Records indicate that Petitioner was referred to physical therapy at [redacted]

[redacted] by a pain management physician. Petitioner reported that in [redacted] 2019, he started having left hand swelling and swelling in the right wrist and in the toes. He reported being prescribed a Medrol Dosepak. Physical examination showed ecchymosis rash in the left big and baby toes and the right baby toes, no breathing difficulty, mild tenderness in the epigastric area but no guarding, mass, rebound or organomegaly, and no swelling, cyanosis or clubbing in the extremities. His neurological exam showed that Petitioner's mental status was intact with normal mood and affect. He had full proximal strength in the lower extremities, DTR was intact and symmetrical, and sensation was intact to light touch in the distal extremities. Rheumatological examination showed the cervical spine had slightly diminished range of motion, no swelling of the right wrist, prominent PIP joint of the fourth and fifth digits but with no tenderness, minimal redness if at all, thoracic or lumbar spine had positive tenderness in the lumbar spine area, good range of motion to the hips and knees with minimal crepitation, noted effusions in the bilateral feet, minimal swelling in the extremities and good pulses in the lower extremities. Petitioner was diagnosed with undifferentiated inflammatory arthritis, especially of the left fourth and fifth digits, although the left wrist had no inflammation. Possible vasculitis of the skin in the lower extremities and toes was noted. Petitioner was to undergo rheumatological studies including x-ray. Petitioner was prescribed Celebrex for pain. Notes also indicate that with respect to Petitioner's chronic bilateral lower back pain, x-rays were reviewed and had normal findings. He was to follow-up with his physical medicine physician for evaluation of sacroiliitis and his cervicalgia. (Exhibit A, pp. 37-52).

Progress notes from Petitioner's visits with [redacted] were presented and reviewed. On [redacted], 2019, Petitioner presented for a consultation and evaluation regarding his back and joint pain. He presented with complaints of back pain and multiple joint discomfort for several years. The doctor indicated that Petitioner recently had a workup with some x-rays of his lumbar and cervical spine, which upon review had essentially normal findings. Petitioner was diagnosed with chronic bilateral low back pain without sciatica, cervicalgia, unspecified joint arthralgia and chronic pain. The doctor indicated that there were no findings of any acute focal neurological deficits and Petitioner did not appear to have any significant joint abnormalities with swelling or malalignment. Notes indicate that Petitioner had possible areas of inflammation for which he was prescribed a Medrol Dosepak and recommended physical therapy. The doctor indicated that an MRI could be ordered if Petitioner's pain did not respond to the treatments, as well as possible injections if anything abnormal was found. The doctor further indicated that there was nothing found that would warrant the need for Petitioner to be on permanent disability, especially given his [redacted] years of age. Upon examination, Petitioner was observed with a cane, but was able to ambulate without this non-antalgic gait. He was also able to do some heel and toe walking, as well as squatting, without significant pain. Examination of the lumbar spine showed that Petitioner was guarded and tender in multiple areas of the lumbar region, but there were no abnormal alignment or palpable masses. Range of motion to the lumbar spine was functional with flexion and extension, despite some complaints of pain. Negative standing flexion test and stork tests bilaterally were noted. Straight leg raising test was negative bilaterally and

there were no obvious signs of instability. His motor strength, bulk, and tone were without obvious abnormalities and his skin also had no visible abnormalities. There were no visible deformities, no tenderness to palpation, and there was full range of motion actively and passively in all joints without pain in both the right and left arms and legs. There was mild tenderness in the paraspinal region of the cervical spine but no palpable masses, and range of motion was functional in all planes; however, there was some mild discomfort with rotation to each side. Petitioner presented for a follow-up appointment on [redacted], 2019. After examination, the doctor indicated that there were no focal neurological deficits and he could not explain the swelling of the left fifth digit, as Petitioner did not report any other injury. Notes indicate that Petitioner's workup so far was normal. He was encouraged to continue with physical therapy and follow-up with rheumatology. The doctor did not find any musculoskeletal abnormalities and there was nothing in the record that seemed to be limiting Petitioner's function. (Exhibit A, pp.95 – 101)

Records from Petitioner's treatment with his primary care physician, [redacted], were reviewed. (Exhibit A, pp. 105-119). On [redacted], 2019, Petitioner presented for an annual preventative exam. Progress notes indicate he was receiving treatment for diagnosis of cervicalgia, and chronic bilateral low back pain without sciatica. Petitioner indicated he had back pain, joint pain, and neck pain. Physical examination indicated that he was oriented to person, place, and time, that he appeared well-developed and well-nourished, that there was normal range of motion to the neck, no reported abnormalities with respect to the cardiovascular examination, and his effort and breath sounds were normal. There was no respiratory distress, no wheezes and no rales. Examination of the abdomen was also normal, with no rebound and no tenderness. Normal range of motion to the musculoskeletal system was noted, his skin was warm and dry with no rash and no erythema. A referral was made to rheumatology and to the physical medicine doctor for further evaluation and management of chronic neck and back pain, as well as chronic joint pain. On [redacted], 2019, Petitioner underwent x-ray imaging of the lumbosacral spine which had normal findings, including normal vertebral body height, alignment, and inter-spacing and no evidence of fracture, dislocation or destructive process. X-ray imaging of the cervical spine completed that same day also had no negative findings or abnormalities, with vertebral body height, alignment, and interspacing all within normal limits as well as no evidence of fracture, dislocation or destructive process. (Exhibit A, pp. 105-119).

Although not reviewed as part of the medical evidence presented to DDS and the Department, Petitioner presented progress notes from his visits with his pulmonologist, [redacted]. (Exhibit 1, pp. 1-13). On [redacted], 2020, Petitioner was evaluated for his shortness of breath. During the appointment, Petitioner reported shortness of breath, cough, sputum, and wheezing. Upon examination, there was no acute respiratory distress, and no other abnormalities with respect to his respiratory system. The doctor indicated that the combination of symptoms Petitioner reported and with his previous exposure to active smoking was suspicious for chronic obstructive pulmonary disease (COPD). Petitioner was prescribed an inhaler and a nebulizer for treatment. A

pulmonary function test did not show any major abnormal findings and there was no evidence of any suspicious pulmonary or pleural abnormality found upon x-ray of the chest.

In [redacted] 2019, Petitioner was referred to physical therapy at [redacted] (Exhibit 1, pp. 43-48).

Petitioner also presented visit notes from a [redacted], 2019 evaluation at the [redacted], where his chief complaint was excessive veins and redness in the eyes, as well as dry and itchy eyes on occasion. There was no major diagnosis or abnormalities noted. (Exhibit 1)

Petitioner's Exhibit 1 contained duplicate records and medical evidence that were also admitted and reviewed in 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 physical 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)), 1.04 (disorders of the spine), 3.02 (chronic respiratory disorders), and 14.09 (inflammatory arthritis) 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 his medical conditions. Petitioner testified that he suffers from severe pain all over his body due to inflammatory arthritis and that he has shortness of breath as a result of his COPD. Petitioner testified that he suffered from a collapsed lung; however, there was no record of this in the medical evidence presented for review and Petitioner was unable to clearly identify when this diagnosis occurred, or the type of treatment sought as a result. Petitioner reported having vasculitis of the skin and indicated that he receives treatment from a rheumatologist, a pulmonologist and his PCP, and was recently referred to a gastroenterologist for his abdominal pain. Petitioner stated that he participated in physical therapy and graduated from his treatment but continues to do home exercises three times per week. It is noted that upon review of the medical evidence submitted, there was no documentation of the physical therapy treatment, with the exception of the referral order and photographs of exercises.

Petitioner testified that he is able to walk for only 10 to 20 yards without the assistance of a cane due to pain in his back, neck, feet and toes. He testified that with a cane, he is able to walk only 30 to 50 yards. Petitioner stated that he uses a cane to assist with ambulation because he feels like his cartilage is tearing each time he walks. However, he confirmed that no physician or medical professional has prescribed or recommended the use of a cane. Petitioner reported that he is able to sit for only 15 to 20 minutes before needing to readjust positions. It was noted that one hour into the hearing, Petitioner remained seated and did not stand or walk around. Petitioner reported that he performed chair yoga while seated during the hearing. He testified that he is able to stand for only a few minutes because of the vasculitis in his toes and the pain in his feet. He reported being able to bend and squat but with excruciating pain. Petitioner reported that he is able to lift a gallon of milk but that he has difficulty gripping and grasping items with his hands due to his inflammatory arthritis and the reported wounds on his hands. Petitioner testified that he lives alone and that he is able to bathe himself, care for his own personal hygiene, and dress himself, however, these tasks are difficult and take longer due to his pain. He testified that he completes chores only one at a time and is unable to complete all chores in one day. He further indicated that he cooks only microwavable meals and that he does his own shopping at the grocery store but uses a motorized scooter.

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 his symptoms. 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 his 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).

Based on the medical evidence presented, as well as Petitioner's testimony, it is found that Petitioner has mild limitations on his 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 in accounting and as professional chauffeur, a security officer, an armored vehicle driver, as a supply chain manager, a bill of materials analyst, a production manager, a financial analyst, and an inventory analyst. Petitioner's employment as an analyst, in accounting, as a supply chain/production manager and as a security officer are categorized as requiring sedentary to light exertion. Petitioner's employment as a professional chauffeur/limousine driver required him to at times lift heavy items including luggage. Thus, it is categorized as requiring medium exertion.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to light work activities and thus, he is not precluded from performing past relevant work due to the exertional requirement of his prior employment. Additionally, as discussed above, Petitioner has a nonexertional RFC imposing only mild limitations in his nonexertional ability to perform basic work activities. After thorough review of the evidence presented, it is found that Petitioner's nonexertional limitations would not preclude him from engaging in sedentary or light work activities on a sustained basis.

Because Petitioner is capable of performing past relevant work, it is found that Petitioner is not disabled at Step 4 and the assessment ends.

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 SDA 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

Susan Noel
26355 Michigan Ave
Inkster, MI
48141

Petitioner

[redacted]

cc: SDA: L. Karadsheh
AP Specialist-Wayne County