[redacted]
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[redacted] MI [redacted]

Date Mailed: July 16, 2020
MOAHR Docket No.: 20-003069
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 June 10, 2020, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Mark Kwarciany, Family Independence Manager.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. Petitioner submitted additional records which were received, marked, and admitted into evidence as Exhibit 1, Exhibit 2, and Exhibit 3. The record was subsequently closed on July 10, 2020 and the matter is now before the undersigned for a final determination on the evidence presented.

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.

2. On or around April 1, 2020, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 30-65)

3. On April 7, 2020, the Department sent Petitioner a Notice of Case Action denying her SDA application and closing her case effective May 1, 2020 based on DDS' finding that she was not disabled. (Exhibit A, pp. 24-29)

4. On April 21, 2020, Petitioner submitted a written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, pp. 459-462)

5. Petitioner alleged mainly mentally disabling impairments due to Post-Traumatic Stress Disorder (PTSD), depression, anxiety, borderline personality disorder, seasonal affective disorder, and bipolar disorder.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1976 date of birth; she was [redacted] and weighed [redacted] pounds.

7. Petitioner completed high school and has past employment history as the CFO of a company she owned with her husband, a peer support specialist and a loader with [redacted] Petitioner has not been employed since May 2016.

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).

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 and in response to the interim order was thoroughly reviewed and is briefly summarized below.

Records from Petitioner's [redacted] 2018 to [redacted] 2020 mental health treatment with Hiawatha Behavioral Health (HBH) were presented and reviewed. (Exhibit A, pp. 150-225). Petitioner was receiving treatment for bipolar affective disorder type I, PTSD, borderline personality disorder, depression, and anxiety. During a [redacted] 2020 medication review visit, there was no indication or complaint of intention of harm towards herself or others, no current indication or complaint of mania, hypomania, active internal stimuli, or delusional thought content. Similar findings were made during her [redacted] 2019 visit. Records from [redacted] 2019 indicate that Petitioner has a lifelong history of mental illness, including several inpatient hospitalization stays, as well as suicide attempts. Her most frequent mental health symptoms included excessive crying, impulsivity/mania, feelings of abandonment, suicidal ideations, poor hygiene, depression, anxiety, and on/off relationships with family. Suicidal ideations and attempts were referenced, as were thought of hurting "people who did [her] wrong." Prior to her treatment at HBH, Petitioner received services through Pathways Community Mental Health in Marquette for 8 years. It was noted that Petitioner had an inpatient hospitalization within the last year at WAR Memorial Hospital and prior to that time, was hospitalized seven times, six at Marquette General and one at Havenwyck. Records indicate that Petitioner has past history of experiencing significant physical and emotional abuse, as well as sexual abuse and rape which affect her daily life. Notes indicate that due to her times of impulsivity, mania, and making poor decisions, she has on-off and strained relationships with her natural supports. Because her father left their family when she was a young child, this has caused her issues in most relationships with significant others, leading to emotional, physical, and sexual abuse. Medication review notes from [redacted] 2019 show that Petitioner displayed mildly dysthymic mood

with occasional, mild tearfulness with congruent, broad affect. During an [redacted] 2019 medication review appointment, Petitioner was noted to have tremulousness which was attributable to her ongoing anxiety and life stressors which have led her to feel on edge, have difficulty with concentration and decreases in mood. Petitioner's medications were adjusted. (Exhibit A, pp. 150-225).

Petitioner's treating psychiatrist, Dr. Meeker, completed a medical needs form on [redacted], 2019, indicating that Petitioner was being treated for bipolar disorder, PTSD, and borderline personality disorder. He notes that Petitioner's illness is chronic, and that medical treatment will be required for the duration of her lifetime, resulting in her inability to work on a permanent basis. (Exhibit A, pp. 243-245)

Petitioner was admitted for inpatient psychiatric treatment to Havenwyck Hospital from [redacted] 2016 to [redacted] 2016 following a suicide attempt by overdosing on her medications. Two prior suicide attempts and a history of approximately six prior inpatient psychiatric hospitalizations were noted, as was sexual abuse history including being raped three times, and physical and mental abuse by her first husband. As the hospitalization continued, Petitioner displayed psychomotor agitation, her affect was labile, her mood was depressed and anxious and her speech pressured. Her thought content showed obsessions, she was observed to be impulsive, compulsive, and that she creates conflict in her family and at work. She experiences suicidal ideation and occasional homicidal ideations, while continuing to express passive suicidal thoughts throughout her hospitalization. She showed signs of severe bipolar one depression, and borderline personality disorder. Her insight and judgment were both fair to poor. Throughout her hospitalization, Petitioner was hyperactive and experienced mood swings. At the time of her discharge, her prognosis was guarded, and she was to continue aftercare mental health treatment with HBH. An assessment completed during the course of Petitioner's inpatient hospitalization indicates that Petitioner reported symptoms of depression, anxiety, mood swings, and suicidal thoughts of overdosing on medications and driving her car into a building. The building that she describes is her former business, which then leads into her homicidal ideations towards her ex-husband. She reported that she wanted to drive her car into the building hoping that he was inside the building so she could hit him. Petitioner presented with tangential speech and had to be redirected several times during the assessment. Petitioner described three previous suicide attempts, two of which were in the form of medication overdose. Her last suicide attempt was a few months prior to the hospitalization, at which time she tried to speed up her vehicle and pressed the brakes for another vehicle to intentionally hit her. The clinical summary of the assessment shows that Petitioner experiences manic symptoms evidenced by her up and down mood swings, impulsive behavior, and labile affect, which then turns euphoric. She is unable to maintain relationships. (Exhibit A, pp. 319-332)

Petitioner presented to the emergency department of Schoolcraft Memorial Hospital on [redacted] 2019 with complaints of sudden pain across her lumbar back, bilateral in nature. She was diagnosed with low back pain with radiculopathy in the left leg. On [redacted] 2019, Petitioner presented to the emergency department and was to be admitted for

inpatient psychiatric hospitalization. She was admitted to War Memorial Hospital. (Exhibit A, pp. 341-351)

On [redacted], 2019, Petitioner was admitted to War Memorial Hospital for increasing violent thoughts and manic behavior. (Exhibit A, pp. 360-371). Upon admission, Petitioner had increased suicidal ideations over the past two weeks, reporting that she was planning to take enough pills to fry her brain. She reported that she had a plan in place, intent, and that she had her dress picked out for her funeral. She reported having violent thoughts of wanting to beat people and stated that she was physically violent during a manic episode in the past. Mental status examination showed that Petitioner had psychomotor agitation, her mood was anxious, depressed and sad, her affect was congruent with her mood which was labile and her affect somewhat flat. She had a flight of ideas and admitted to having homicidal ideations but denied thinking she would go through with it. She admitted to having nightmares about her husband's step-dad giving her a gun and her using it shoot herself in the head. Her concentration and attention span were noted to be poor and her judgment/insight were fair to poor. Thoughts associated with manic episodes, such as adopting a cat, wanting to shave her head, gambling, wanting to burn herself, and feeling promiscuous were also noted. She reported history of physical, emotional, and sexual abuse. Decompensation in symptoms was noted, as was mood lability and feelings of unstableness. Petitioner was discharged on or around [redacted] 2019 and was to participate in outpatient mental health treatment. (Exhibit A, pp. 360-371)

Records from Petitioner's [redacted] 2016 to [redacted] 2017 treatment with OSF Gladstone were presented and reviewed. (Exhibit A, pp. 376-458). Petitioner was receiving treatment for bipolar affective disorder, currently depressed moderate, suicidal behavior with attempted self-injury with use of clonazepam overdose resulting in hospitalization, manic disorder, recurrent episode, severe depression, insomnia related to medical conditions, and night sweats due to medications. In [redacted] 2016, Petitioner presented for a follow-up appointment post hospitalization for suicidal attempt after visiting family in South Dakota. Petitioner was admitted for inpatient psychiatric treatment at Avera Hospital and reported that she was gambling and took an overdose of Klonopin after losing substantial amounts of money. She was manic and had severe depression and reported nightmares. In [redacted] 2016, Petitioner presented for follow-up after her recent hospitalization at Havenwyck Hospital for suicidal thoughts and severe depression. She continued to struggle with anxiety and depression following her discharge from the hospital, as well as the other multiple issues detailed in the records documenting her hospital admission. Petitioner was to continue her mental health treatment at HBH. During her [redacted] 2016 visit, Petitioner presented with worsening anxiety and depression, reported feeling chronically tense and anxious, had difficulty concentrating, was tearful and reported that her medications were not helpful. While she had no manic features, her mood was depressed, affect was flat, and her insight was limited. (Exhibit A, pp. 376-458).

Although not considered objective medical evidence, Petitioner's mother wrote a letter on her behalf detailing Petitioner's history of mental health impairments dating back to age 4 and continuing through the present time. Associated symptoms were noted to be

mood swings with daily disruptions, suicidal tendencies with depression, and abusive relationships. The letter further references Petitioner's prior employment with [redacted] her ex-husband's company, and the chaos that Petitioner created there due to her frequent highs and lows including, overly generous giving to employees, her extremely publicly abusive relationship with her husband, her public displays of tantrums, hollering and screaming, as well as inappropriate sexual behaviors. Petitioner was asked to leave the company legally, as she was in no emotional, mental or physical shape to help operate a business. (Exhibit 1)

Petitioner presented a Medical Source Statement of Ability to do Work-Related Activities (Mental) completed on [redacted], 2020 by her treating psychiatrist since 2017, Dr. Meeker. (Exhibit 2). Dr. Meeker's assessment indicated that Petitioner was moderately limited in her ability to understand and remember short, simple instructions; carry out short, simple instructions, and in her ability to make judgments on simple work-related decisions. Petitioner was markedly limited in her ability to understand and remember detailed instructions; to carry out detailed instructions; in her ability to interact appropriately with the public, with her supervisor, with coworkers, with her ability to respond appropriately to work pressures and usual work setting. It was noted that Petitioner's ability to respond appropriately to supervision, coworkers, and work pressures in any work setting was affected by her mental impairments. Petitioner was found to be extremely limited in her ability to respond appropriately to changes in a routine work setting. Dr. Meeker indicated that Petitioner has poor reactions to stress, marked lability mood/behavior and limited attentiveness. He noted that even with ongoing care, Petitioner has intense periods of decompensation due to long-standing severe and chronic mental health issues. (Exhibit 2)

Kellie Campbell, Petitioner's treating therapist through HBH, authored a letter on Petitioner's behalf which was presented and reviewed. Ms. Campbell indicated that Petitioner's mental health history includes several psychiatric inpatient hospitalization stays, suicide attempts, thoughts of hurting others, as well as bouts of extreme mania and impulsivity which have impacted her daily life. Her daily symptoms include, but are not limited to, excessive crying, feelings of abandonment, depression, anxiety, panic attacks, social isolation, poor hygiene, as well as strained on and off relationships with her natural supports. (Exhibit 3)

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), 12.08 (personality and impulse control disorders), and 12.15 (trauma-and stressor-related disorders) 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).

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). Where the evidence establishes a medically determinable mental impairment, the degree of functional limitation must be rated, taking into consideration chronic mental disorders, structured settings, medication, and other treatment. The effect on the overall degree of functionality is evaluated under four broad functional areas: (i) understand, remember, or apply information; (ii) interact with others; (iii) concentrate, persist, or maintain pace; and (iv) adapt or manage oneself. 20 CFR 416.920a(c)(3), to which a five-point scale is applied (none, mild, moderate, marked, and extreme). 20 CFR 416.920a(c)(4). The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. 20 CFR 416.920a(c)(4).

In this case, Petitioner alleged mainly nonexertional mental limitations due to her impairments. Petitioner testified that she was diagnosed with bipolar disorder as a child and has been receiving mental health treatment since that time. She currently suffers from borderline personality disorder, PTSD due to her abuse history, bipolar disorder, depression, and anxiety for which she receives treatment through therapy and medication management. Petitioner testified that she has been hospitalized for inpatient psychiatric treatment at least 15 times over the past 20 years, most recently in 2019 after suffering a hypomanic episode that lasted six months. Petitioner stated that during her manic episodes, she makes extremely poor decisions, is very volatile, has delusions of grandeur, and resorts to her gambling addiction among other things. Petitioner testified that when she is not suffering from a manic episode, she is in a deeply depressive state during which it is difficult to function. Petitioner reported that she suffers from anxiety and panic attacks, that her legs go numb, her head and body

shake, her hands clamp up and that she can no longer speak. She indicated that it is extremely difficult for her to handle stressful situations, that she is unable to focus longer than two minutes and that noise makes it difficult for her to concentrate. She indicated she is unable to follow verbal directions, as her memory lapses and that she has a hard time interacting with other people. Petitioner testified that she suffers from crying spells during her episodes and that she has visual hallucinations of spiders and mice that are not real. Petitioner testified that she is often violent, and has homicidal thoughts of hurting others, which led to an inpatient hospitalization. She also has suicidal ideations and has made multiple attempts over the last several years. Although Petitioner stated that she does not have exertional limitations towards her daily activities, during episodes of mania and depression, Petitioner is unable to complete daily activities.

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. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, some of which are referenced above 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 medical record presented, as well as Petitioner's testimony, Petitioner has moderate to marked limitations in her ability to understand, remember, or apply information; to interact with others; in her ability to concentrate, persist, or maintain pace, and in ability to adapt or manage oneself. Petitioner's nonexertional RFC is considered at both Steps 4 and 5.

Step Four

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of work as the CFO of a company she owned with her husband, a peer support specialist, and a loader

with [redacted] Upon review, Petitioner's prior employment is categorized as requiring sedentary to medium exertion. Although based on the RFC analysis above, Petitioner's exertional RFC limits her to light work activities and thus, she is not precluded from performing past relevant work due to the exertional requirement of her prior employment, Petitioner has additional nonexertional limitations that would prevent her from being able to perform past relevant work. Therefore, she cannot be found disabled, or not disabled at Step 4 and the assessment continues to Step 5.

Step 5

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

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

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

However, when a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be a younger individual (age 18-44) for purposes of Appendix 2. She is a high school graduate who has unskilled to semi-skilled work history that is nontransferable. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform light work activities. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled.

However, as discussed above, Petitioner has moderate to marked limitations in her ability to understand, remember, or apply information; to interact with others; in her ability to concentrate, persist, or maintain pace, and in her ability to adapt or manage oneself. The Department has failed to present evidence of a significant number of jobs in the national and local economy that Petitioner has the vocational qualifications to perform in light of her mental nonexertional RFC, age, education, and work experience. Therefore, the evidence is insufficient to establish that Petitioner is able to adjust to other work. Accordingly, Petitioner is found disabled at Step 5 for purposes of the SDA benefit program.

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; and

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

Zainab Baydoun

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

Joan King
305 Ludington St.
Escanaba, MI 49829

Petitioner

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

cc: SDA: L. Karadsheh
AP Specialist, Delta (1)