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[redacted], MI [redacted]

Date Mailed: June 22, 2020
MOAHR Docket No.: 20-003070
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 three-way hearing was held on June 17, 2020, from Clawson, Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Lianne Scupholm, Hearing Facilitator.

ISSUE

Whether the Department properly determined that Petitioner was not disabled for purposes of continued 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. Petitioner was an ongoing recipient of SDA benefits based on a determination by the Disability Determination Services'(DDS) approval of her application of August 7, 2018. DDS directed that the Department medically review Petitioner's medical condition and ongoing eligibility for SDA in November 2019 (Exhibit A, p. 363).

2. On November 16, 2018 the DDS Decision found that Petitioner was disabled because of chronic back and knee pain, BMI 48.73 (morbid obesity), MRI L5-S1 disc extrusion, multilevel lumbar spondylosis, right hip advanced osteoarthritis end stage, ambulates with cane, noted anxiety and has home help care by her son for ADLs and shoe sock dressing . The DDS found the Petitioner met Social Security Disability Listing 1.02 Major Dysfunction of a joint any cause. Exhibit A, p. 363 and 365.

3. In connection with a November 1, 2019 review, DDS determined on December 18, 2019 that Petitioner's condition had not worsened or deteriorated and her condition is stable and she has not suffered any complications or infections. DDS concluded that Petitioner was no longer disabled. (Exhibit A, pp. 14).

4. On December 20, 2019, the Department sent Petitioner a Notice of Case Action notifying her that her SDA case would close effective February 1, 2020 because, among other things, she was not disabled (Exhibit A, pp. 4-8).

5. On March 16, 2020, the Department received Petitioner's timely written request for hearing disputing the closure of her SDA case.

6. Petitioner alleged disabling impairment due to end state osteoarthritis of the right hip, and osteoarthritis of right knee, morbid obesity, fibromyalgia, diabetes mellitus, type two not controlled, Stage III kidney disease, hypertension, chronic low back pain. The Petitioner also alleged depression and anxiety.

7. At the time of hearing, Petitioner was [redacted] years old with a [redacted], [redacted] birth date; she is [redacted]" in height and weighs about [redacted] pounds.

8. Petitioner completed high school and a second year of college online.

9. Petitioner has an employment history of work as a as a data entry clerk and cashier.

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 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.

A disabled person is eligible for SDA. BEM 261 (July 2014), 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 lasting, or expected to last, 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).

Once an individual has been found disabled, continued entitlement to benefits based on a disability is periodically reviewed in accordance with the medical improvement review standard in order to make a current determination or decision as to whether disability remains. 20 CFR 416.993(a); 20 CFR 416.994(a). If the individual is not engaged in substantial gainful activity (SGA), the trier of fact must apply an eight-step sequential evaluation in evaluating whether an individual's disability continues. 20 CFR 416.994. The review may cease and benefits may be continued at any point if there is sufficient evidence to find that the individual is still unable to engage in SGA. 20 CFR 416.994(b)(5). In this case, Petitioner has not engaged in SGA at any time since he became eligible for SDA. Therefore, his disability must be assessed to determine whether it continues.

An eight-step evaluation is applied to determine whether an individual has a continuing disability:

> **Step 1.** If the individual has an impairment or combination of impairments which meets or equals the severity of an impairment listed in 20 CFR Appendix 1 of subpart P of part 404, the disability will be found to continue. 20 CFR 416.994(b)(5)(i).
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> **Step 2.** If a listing is not met or equaled, it must be determined whether there has been medical improvement as defined in paragraph (b)(1)(i) of 20 CFR 416.994 and shown by a decrease in medical severity. If there has been a decrease in medical severity, Step 3 is considered. If there has been no decrease in medical severity, there has been no medical improvement unless an exception in Step 4 applies. 20 CFR 416.994(b)(5)(ii).
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> **Step 3.** If there has been medical improvement, it must be determined whether this improvement is related to the individual's ability to do work in accordance with 20 CFR 416.994(b)(1)(i) through (b)(1)(iv); *i.e.*, there was an increase in the individual's residual functional capacity (RFC) based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to the individual's ability to do work, the analysis proceeds to Step 4. If medical improvement *is* related to the individual's ability to do work, the analysis proceeds to Step 5. 20 CFR 416.994(b)(5)(iii).
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> **Step 4.** If it was found at Step 2 that there was no medical improvement or at Step 3 that the medical improvement is not related to the individual's ability to work, the exceptions in 20 CFR 416.994(b)(3) and (b)(4) are considered. If none of them apply, the disability will be found to continue. If an exception from the first group of exceptions to medical improvement

applies, the analysis proceeds to Step 5. If an exception from the second group of exceptions to medical improvement applies, the disability is found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process. 20 CFR 416.994(b)(5)(iv).

Step 5. If medical improvement is shown to be related to an individual's ability to do work or if one of the first group of exceptions to medical improvement applies, **all** the individual's current impairments in combination are considered to determine whether they are severe in light of 20 CFR 416.921. This determination considers all the individual's current impairments and the impact of the combination of these impairments on the individual's ability to function. If the RFC assessment in Step 3 shows significant limitation of the individual's ability to do basic work activities, the analysis proceeds to Step 6. When the evidence shows that all the individual's current impairments in combination do not significantly limit the individual's physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature and the individual will no longer be considered to be disabled. 20 CFR 416.994(b)(5)(v).

Step 6. If the individual's impairment(s) is severe, the individual's current ability to do substantial gainful activity is assessed in accordance with 20 CFR 416.960; i.e., the individual's RFC based on all current impairments is assessed to determine whether the individual can still do work done in the past. If so, disability will be found to have ended. 20 CFR 416.994(b)(5)(vi).

Step 7. If the individual is not able to do work done in the past, the individual's ability to do other work given the RFC assessment made under Step 6 and the individual's age, education, and past work experience is assessed (unless an exception in 20 CFR 416.994(b)(5)(viii) applies). If the individual can, the disability has ended. If the individual cannot, the disability continues. 20 CFR 416.994(b)(5)(vii).

Step 8. Step 8 may apply if the evidence in the individual's file is insufficient to make a finding under Step 6 about whether the individual can perform past relevant work. If the individual can adjust to other work based solely on age, education, and RFC, the individual is no longer disabled, and no finding about the individual's capacity to do past relevant work under Step 6 is required. If the individual may be unable to adjust to other work or if 20 CFR 416.962 may apply, the individual's claim is assessed under Step 6 to determine whether the individual can perform past relevant work. 20 CFR 416.994(b)(5)(viii).

Step One

Step 1 in determining whether an individual's disability has ended requires the trier of fact to consider the severity of the impairment(s) and whether it meets or equals a listed impairment in Appendix 1 of subpart P of part 404 of Chapter 20. 20 CFR 416.994(b)(5)(i). If a listing is met, an individual's disability is found to continue with no further analysis required.

The medical record presented was reviewed and is briefly summarized below.

The Petitioner was seen on September 17, 2019 at [redacted] physical therapy regarding knee pain and requested a brace, the Petitioner reported that physical therapy has helped and the tens unit helps but she has had not much relief. Petitioner reports dealing with a lot of pain. The assessment was arthritis of the right hip, decreased range of right hip movement, muscle weakness, difficulty walking and unsteadiness on feet. The notes indicate that Petitioner had some improvement in mobility although improvement was slow. Notes further indicate that Petitioner would likely be unable to perform a standing or active job although part-time perhaps a sedentary job might be possible although Petitioner has very limited sitting tolerance as well and much difficulty with transitions from sitting to standing. Home therapy was also suggested as more appropriate for Petitioner. Evaluation notes indicate that the Petitioner's physical therapy goals were not met, including reducing pain with community walking, maintain a balance for 30 seconds, pain of less than 3, standing for 10 to 15 minutes, demonstrate ability with the right knee extension to 0°, demonstrate ankle dorsiflexion, demonstrate 4/5 right hip abduction strength and demonstrate 4/5 right knee total active motion strength. At that time Petitioner had completed all of her therapy and would continue with home therapy exercises., Notes of physical therapy from September 10, 2019 further indicate that most of the hip exercises and treatment are done with pain and her hip strength was 3/5 and 3/4 internal hip rotation and external rotation 2/5. Comments were added indicating Petitioner was unable to stand and fully bear weight on the right lower extremity and further notes therapeutic exercise consisted of two minutes of seated bike pedaling. The notes do indicate that the Petitioner was not able to tolerate squatting movements as necessary during daily activities without cramping, but was able to walk short distances around the home. During physical therapy on August 27, 2019 the Petitioner reported very painful hip and transitions were noted as painful. The therapeutic standing extension for anterior hip stretching one set of 10 was completed. Petitioner continued to have difficulty tolerating exercises and is not able to lift right leg past neutral into flexion due to severe pain and modifies all movements with transitions and sitting positioning to accommodate pain. At a session on August 13, 2019 Petitioner reported 20% improvement in strength. Left knee flexion was noted to be with in normal limits most of the exercises regarding her hip were performed with pain and several including hip external rotation right and hip internal rotation right were not able to be performed. The notes further indicate that the patient is compliant. Progress notes indicate that Petitioner is very limited in her ability to ambulate in the home, perform transitions and tolerate range of motion. Slow progress towards functional goals reported. Notes further indicate Petitioner has decreased mobility in the right knee and does not tolerate more than 5° of flexion at the

knee. In a session on July 26, 2019 therapist notes indicate focus on gaining strength and range of motion, patient is compliant but requires rest breaks. On July 19, 2019 a review of systems indicated that several limitations included gait limitation, walking household distances was rated as severe and was unable to walk community distances, unable to lift an object from the floor, unable to ascend four stairs reciprocally or descend reciprocally, standing limitation was two minutes, noted rolling in bed, in and out of bathtub and in and out of the car as causing severe pain limitations, and sitting limitation was five minutes. Additional limitations also noted were driving, vacuuming, dusting, dishes, cook a meal, dressing, and putting on shoes and socks. Sitting and standing for an hour were also indicated extreme of difficultly and running on even ground was unable to be performed. Testing also noted that right knee flexion and extension was significantly limited as compared to the left knee. At the initial assessment the Petitioner was evaluated as severely limited right hip range of motion with pain in all active movements and demonstrated significant impairments in right knee range of motion as well. Petitioner was unable to weight bear on the right side and did not demonstrate adequate mobility to allow sitting with normalized positioning. Fall risk status was also noted due to functional mobility impairments and the conditioning. Given the Petitioner's low tolerance treatment modifications were made.

On October 23, 2019 the Petitioner participated in an individual psychotherapy session at which time she reported remaining depressed over her health issues. During the session the Petitioner was reported as verbally engaged and cooperative and was encouraged to make her needs known. Attendance records indicate Petitioner is seen once monthly by her therapist. Mental status was noted as unremarkable, mood euthymic, affect full, speech clear, thought process logical, perception within normal limits, no hallucinations, and no delusions reported. The diagnosis was depression, major recurrent moderate and social anxiety disorder. Records indicate that the Petitioner is prescribed Buspirone for her mental health issues. In August 14, 2019 progress note indicated Petitioner continues to work on not letting her depression control the functioning of day-to-day activities. Petitioner was alert and oriented at the session and reported attempting to address her health concerns. Reported attending physical therapy and feeling better and working on self-care. Petitioner was seen on July 24, 2019 and reported doing better with her depression. She is attempting to concentrate on self-care and keep herself up. Notes indicate Petitioner has attempted to lose weight so that she can have a hip replacement. On July 10, 2019 Petitioner reported stomach problems and that her health problems are making her feel depressed preventing her from doing anything. Petitioner again reports depression due to her health problems and is worried about her weight with the goal of losing 10 pounds in two months. At a session on May 1, 2019 Petitioner reported a death in the family due to a shooting and was attempting to be strong for her sister. At a session on April 10, 2019 Petitioner reported she is no longer able to take care of her day to day needs and feels badly having to rely on her adult son. Physical therapy was recommended but at that time she was unable to do the therapy due to pain. During all of the sessions, notes indicate that Petitioner is alert, oriented, able to make her and needs known, verbally engaged and cooperative with no suicidal or homicidal ideation.

On December 12, 2019 the Petitioner had an intake examination by her mental health provider at which time she reported struggling with depression and anxiety and with transportation problems. Notes indicate that when she is depressed she eats has crying spells, freaks out and deals with emotions. The symptoms of illness also included being overweight and needing a hip replacement and being somewhat financially dependent on her mother as she struggles with paying the water and gas bills. Finances are very discouraging for her. Problems with her feet and hip have limited her mobility. She describes symptoms of hyperventilation, restlessness, emotional lability, shortness of breath, light headedness and dizziness. Petitioner reported receiving counseling services at [redacted] and does not feel her current medications are helping her. At the time health concerns included pain in the back, feet, knees, hip, diabetes, hypertension and kidney problems. The following observations were made during her intake exam her mental status was depressed, anxious and tearful with full affect, clear speech logical thought process without hallucinations or delusions with a depressed thought content and intelligence above average, her insight was within normal limits and judgment within normal limits. With regard to her appearance, Petitioner was well groomed, but was non-ambulatory and in a wheelchair, her activity was slowed and lethargic, Petitioner's attitude toward examiner was cooperative. At the conclusion of intake the diagnosis was depression, major recurrent, moderate and social anxiety disorder. With regard to anxiety the Petitioner reported that she felt nervous or anxious more than half the days during a two week period and not able to stop worrying, worrying too much, and expressed trouble relaxing several days out of a two week period. Based on the answers to the questions the Examiner felt the anxiety displayed was mild.

On April 19, 2019 the Petitioner was seen for a well woman annual health exam the problem list noted diabetes type II, hypertension, osteoarthritis of the hip, chronic low back pain and hypothyroid. During the examination and review of systems abdominal pain and nausea was reported, as was depression and insomnia at the exam the Petitioner weighed [redacted] pounds. The exam was essentially normal except that abnormal uterine bleeding was reported.

On October 24, 2019 the Petitioner was seen in her doctor for right foot bilateral pain and ankle pain. At the time of the exam the Petitioner was largely non-ambulatory and in a wheelchair. She had completed physical therapy with little improvement. Petitioner requested a steroid injection and states that her symptoms are constant with intermittent worsening which are aggravated by walking. The physical exam indicated tenderness to palpation of the right ankle with out in any instability with diffuse edema to her feet and legs. Her foot and ankle demonstrated active range of motion and poor neurovascular reflexes, sensation and pulses were within normal limits. A diabetic foot screen was negative. The Petitioner received a right ankle joint injection. The Petitioner also had a biopsy taken of two lesions located on the right foot. The assessment was neoplasm of unspecified behavior of bone, soft tissue and skin. The Impression was bilateral foot pain likely secondary to peripheral neuropathy. EMG showed severe axonal sensorimotor neuropathy. Nothing further to alleviate the situation could be offered as she is currently taking Lyrica.

Petitioner was seen for follow up for diabetes and renal disorder on September 18, 2019 and an 18 pound weight loss and was reported and Petitioner was considered morbidly obese with exercise intolerance. Diabetes medication changed to Victoza to check for side effects and Free Style Libre.

On September 16, 2019 the Petitioner was seen for diabetes, hypertension, constipation and musculoskeletal pain. Notes report Petitioner is doing insulin four times per day and is managed with diet, insulin and fingerstick bloods sugars. Also reported was constipation with abdominal pain, bloating and flatulence. Right knee anterior onset of pain three months ago was reported. The pain is aching and throbbing with no known injury. Pain is aggravated by climbing stairs, movement, walking and standing. Pain has been relieved by heat, injection and icy heat. Symptoms include crepitus, decreased mobility, joint tenderness, limping, nocturnal awakening, nocturnal pain swelling and weakness. The right knee was noted for swelling and decreased range of motion with pain on palpation. With respect to the assessment the Petitioner was to continue checking blood sugars as recommended and increase physical activity. With regard to hypertension, medications were continued for high blood pressure and Petitioner was encouraged to increase activity to at least 30 minutes most days of the week. An x-ray of her right knee was taken and a referral to an orthopedic doctor if needed and/or more physical therapy. Due to swelling of her right lower extremity arterial ultrasound was ordered with a unilateral lower extremity study to be performed.

The Petitioner was referred to a diabetes specialist on September 8, 2019. Notes indicate diabetic onset at age 25 with diabetic neuropathy, hypertension, hyperlipidemia and kidney disease and gastroparesis. The stage III kidney disease was noted as stable. Additional medications for hypothyroidism were prescribed. The notes further indicate body met mass index is well over 40, notes that patient is severely obese. Petitioner was directed to check her insulin four times a day, and check food choices leading to highs and lows. When seen on August 8, 2020 Petitioner reported 30 pound weight loss, muscle weakness, arthralgias and right hip pain, back pain and swelling of extremities with sharp pains in feet bilaterally without numbness and depression and anxiety. The Petitioner was noted as morbidly obese and in a wheel chair.

On July 16, 2019, the Petitioner was seen for a doctor visit regarding hypertension, diabetes and anxiety. Notes indicate that the patient had presented with anxious/fearful thoughts, compulsive thoughts and excessive worry but denied difficulty concentrating, falling asleep or staying asleep. Petitioner noted diminished interest or pleasure, fatigue and no thoughts of death or suicide. The assessment/plan indicated current medications were to be continued for hypertension and good progress by Petitioner with low sodium diet. She was to check her blood pressure at home or in a pharmacy weekly and to exercise 30 minutes per day. As regards diabetes due to obesity, hypertension and uncontrolled diabetes a recommendation to take Victoza to lower blood glucose levels and reduce cardiovascular risk was made. Notes also indicate metformin and glipizide had to be stopped due to Petitioner’s renal function. As regards anxiety, Buspar was increased 10 mg twice per day.

On July 11, 2019 the Petitioner was seen by her doctor for diabetes, hypertension and musculoskeletal pain and Gerd. Notes indicate diabetes was getting worse and that patient is compliant with using medication. With regard to hypertension, the notes indicate a risk factor due to inactive lifestyle, obesity and sleep apnea. With respect to musculoskeletal pain with onset five years ago the location indicated was right lower back with aching throbbing pain aggravated by bending, climbing and descending stairs, movement, sitting, walking and standing. Pain is somewhat relieved with heat, ice massage and physical therapy with symptoms of crepitus, decreased mobility, difficulty initiating sleep, joint instability, joint tenderness, limping, nocturnal awakening, nocturnal pain and weakness. Petitioner's weight was 359 pounds. During the examination limited range of motion due to pain and limited strength 3/5 was noted. With regard to right hip arthritis and pain, a referral for physical therapy to evaluate and treat was made. With respect to bilateral low back pain without sciatica, physical therapy had not improved the lower back pain but tens unit has been started.

A doctor's visit on March 12, 2019 indicate that Petitioner is assisted in activities of daily living with by her son which include cooking, cleaning, laundry, grocery shopping and assisting with shoes and socks on a daily basis. Petitioner unable to drive herself to appointments and requires her son to transport her. The assessment and plan notes that she requires assistance on a daily basis from her son. On February 12, 2019 at an office visit Petitioner was seen due to musculoskeletal pain the severity level being high and location right hip and back pain. Associated symptoms noted as crepitus, decreased mobility, joint instability, joint tenderness, limping, nocturnal awakening and pain, spasms and weakness. At the conclusion of the session an assessment of fibromyalgia was made as well as idiopathic aseptic necrosis of unspecified femur, chronic, with a plan of providing a walker with a seat. On January 8, 2019 the Petitioner was seen for hypertension and muscle spasms which had increased.

Petitioner was seen on August 7, 2019 by [redacted] for a new consult. Notes indicate that Petitioner currently ambulates by wheelchair and walker, was morbidly obese, BMI 49.51 and poorly controlled diabetes with las A1C greater than 9. Weight loss was due to attending classes for weight loss decreasing weight from 370 to 355 pounds. During the physical exam, Petitioner was positive for back pain and joint pain and shortness of breath and sitting in wheelchair due to extreme obesity. The Assessment was chronic Gerd, obesity due to excess calories, chronic constipation and Type 2 diabetes mellitus with complication and long term insulin use and presents with depressed mood. Petitioner was seen for diabetic gastroparesis, Gerd. The notes of the consult indicate that surgery was discussed but was unclear as to the type of procedure. Petitioner was in a wheelchair.

The Petitioner was seen on February 22, 2019 for chronic stage III kidney disease with signs of anemia. The notes of the visit indicate that that Petitioner has had kidney disease since 2017 due to diabetes and hypertension. Chronic kidney disease was stable.

A follow up for kidney disease was conducted on November 7, 2019 and noted BMI of 48.9 and weight of 350 pounds noted as severely obese. The Petitioner reported a 12 pound weight gain and exercise intolerance. Petitioner reported numbness and arthralgias with joint pain and back pain. Petitioner's diabetes medication was changed to Ozempic due to insurance. Petitioner hypothyroidism was elevated and medication was prescribed.

Petitioner was administered a sleep study and results were dated August 28, 2019. The Petitioner was diagnosed with obstructive sleep apnea. Petitioner was using a CPAP machine. The patient reported awakening feeling more rested and some improvement in daytime functioning pre-PAP period. Estimated BMI was 48.9. Sleep apnea was well controlled.

On October 22, 2019 the Petitioner underwent a lower extremity arterial duplex arterial flow study. BMI was 49.53 and weight 354.95. Results indicate no significant stenosis or occlusion with normal perfusion right lower extremity. On the left lower extremity doppler waveforms were triphasic throughout left lower extremity, with digital pressures adequate and inadequate for healing.

On October 18, 2019 the x-ray of right knee three view were taken due to acute pain. The Impression was mild degenerative joint disease predominantly involving the patellofemoral joint.

Evidence of osteoarthritis of the right hip at the time of her last approval a May 2018 hip x-ray examination noted advanced osteoarthritis of right hip joint noted destruction of superior aspect of the hip joint and bony sclerosis of acetabulum and the femoral head with subchondral cysts and spurring. No updated x-rays were available and Petitioner has not had any surgery on her right hip since May 2018, thus no change, improvement has been demonstrated.

In light of the medical evidence presented, listings 1.02 (major dysfunction of a joint), 1.04 (disorders of the spine), 12.04 (affective disorders), 12.06 (anxiety-related disorders), and 12.08 (personality disorders) were considered.

After a review of the medical evidence presented it is determined that the Petitioner continues to meet the equivalent of Listing 1.02 Major dysfunction of a joint(s) due to any cause based upon her inability to ambulate effectively on a sustained basis, based upon the medical evidence presented and her advanced end stage osteoarthritis of the right hip. The evidence demonstrated that Petitioner requires assistance with her ADLs, and the evidence did not demonstrate that she was capable of a walking pace over a sufficient distance to be able to carry out activities of daily living and is required to be driven to all appointments, uses a walker, cane and wheelchair as required and is not able to walk independently about her home without the use of an assistive device. Petitioner's morbid obesity was also considered in making this determination.

Because the medical evidence presented demonstrated that Petitioner's impairments meet or equal the required level of severity of listing 1.02 in Appendix 1, Petitioner is considered as continuing to be disabled and no further analysis or consideration is required.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds Petitioner **has** a continuing disability for purposes of the SDA benefit program. Therefore, Petitioner's SDA eligibility **continues** and the Department **did not act** in accordance with Department policy when it closed her SDA case.

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. Reinstate Petitioner's SDA case effective February 1, 2020;

2. Issue supplements to Petitioner for any lost SDA benefits that she was entitled to receive from February 1, 2020 ongoing if otherwise eligible and qualified in accordance with Department policy;

3. Notify Petitioner of its decision in writing; and

4. Review Petitioner's continued SDA eligibility in June 2021 in accordance with Department policy.

LF/

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

Via Email:

MDHHS-Calhoun-Hearings
BSC3 Hearing Decisions
L. Karadsheh
MOAHR

Petitioner – Via First-Class Mail:

[redacted], MI [redacted]