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MI [redacted]

Date Mailed: March 4, 2021
MOAHR Docket No.: 20-008589
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 February 16, 2021, from Lansing, Michigan. Petitioner [redacted] appeared at the hearing and self-represented. The Department of Health and Human Services (Department) was represented by Tamara Jackson, Hearings Facilitator.

Department's Exhibit A pages 1-1490 were admitted as evidence.

Petitioner waived the timeliness standard and requested to submit additional information. On February 18, 2021, the undersigned Administrative Law Judge issued an Interim Order leaving the record open until February 23, 2021. On March 1, 2021, Petitioner submitted Petitioner's Exhibit 1 pages 1-205 in additional Medical Information which was admitted to the record.

ISSUE

Whether the Department properly determined 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 [redacted], 2020, Petitioner filed an application for State Disability Assistance (SDA) benefits alleging disability.

(2) Petitioner receives Medical Assistance and Food Assistance Program benefits.

(3) SDA benefits were approved for COVID-19 relief.

(4) On June 10, 2020, the Medical Review Team denied Petitioner's application stating that Petitioner could perform other work.

(5) On September 23, 2020, the Department caseworker sent Petitioner notice that his application was denied.

(6) On December 8, 2020, Petitioner filed a request for a hearing to contest the Department's negative action.

(7) On February 16, 2020, the hearing was held.

(8) Petitioner is a [redacted]year-old man whose date of birth is [redacted], 1973. He is [redacted]" tall and weighs [redacted] lbs. He has a 12th grade education.

(9) Petitioner can read and write, add, subtract and count money. He is not working. He lives in a house with his mother in his uncle's trailer.

(10) Petitioner last worked in 2009 as a cook in a restaurant. He has also worked in factories.

(11) Petitioner alleges as disabling impairments: Bipolar disorder, depression, anxiety, closed head injury, neuropathy in hands and feet, hypertension, osteomyelitis in the right foot, hernia surgery (February 2020), right knee problems, peripheral vascular disease and degenerative disc disease.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

Department policies are contained in the following Department of Health and Human Services Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and 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 person is considered disabled for SDA purposes if the

person has a physical or mental impariment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

Pursuant to Federal Rule 42 CFR 435.540, the Department of Human Services uses the federal Supplemental Security Income (SSI) policy in determining eligibility for disability under the Medical Assistance program. Under SSI, disability is defined as:

> ...the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.... 20 CFR 416.905

A set order is used to determine disability. Current work activity, severity of impairments, residual functional capacity, past work, age, or education and work experience is reviewed. If there is a finding that an individual is disabled or not disabled at any point in the review, there will be no further evaluation. 20 CFR 416.920.

If an individual is working and the work is substantial gainful activity, the individual is not disabled regardless of the medical condition, education and work experience. 20 CFR 416.920(c).

If the impairment or combination of impairments do not significantly limit physical or mental ability to do basic work activities, it is not a severe impairment(s) and disability does not exist. Age, education and work experience will not be considered. 20 CFR 416.920.

Statements about pain or other symptoms do not alone establish disability. There must be medical signs and laboratory findings which demonstrate a medical impairment.... 20 CFR 416.929(a).

> ...Medical reports should include –
>
> (1) Medical history;
>
> (2) Clinical findings (such as the results of physical or mental status examinations);
>
> (3) Laboratory findings (such as blood pressure, X-rays);
>
> (4) Diagnosis (statement of disease or injury based on its signs and symptoms).... 20 CFR 416.913(b).

The person claiming a physical, or mental, disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for a recovery and/or medical assessment of ability to do work-related activities, or ability to reason and to make appropriate mental adjustments, if a mental disability is being alleged. 20 CRF 416.913.

In determining disability under the law, the ability to work is measured. An individual's functional capacity for doing basic work activities is evaluated. If an individual has the ability to perform basic work activities without significant limitations, he or she is not considered disabled. 20 CFR 416.994(b)(1)(iv).

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include --

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting. 20 CFR 416.921(b).

Medical findings must allow a determination of (1) the nature and limiting effects of your impairment(s) for any period in question; (2) the probable duration of the impairment; and (3) the residual functional capacity to do work-related physical and mental activities. 20 CFR 416.913(d).

Medical evidence may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of the impairment(s), including your symptoms, diagnosis and prognosis, what an individual can do despite impairment(s), and the physical or mental restrictions. 20 CFR 416.927(a)(2).

All of the evidence relevant to the claim, including medical opinions, is reviewed and findings are made. 20 CFR 416.927(c).

The Administrative Law Judge is responsible for making the determination or decision about whether the statutory definition of disability is met. The Administrative Law Judge reviews all medical findings and other evidence that support a medical source's statement of disability.... 20 CFR 416.927(e).

A statement by a medical source finding that an individual is "disabled" or "unable to work" does not mean that disability exists for the purposes of the program. 20 CFR 416.927(e).

When determining disability, the federal regulations require that several considerations be analyzed in sequential order. If disability can be ruled out at any step, analysis of the next step is not required. These steps are:

1. Does the client perform Substantial Gainful Activity (SGA)? If yes, the client is ineligible for MA. If no, the analysis continues to Step 2. 20 CFR 416.920(b).

2. Does the client have a severe impairment that has lasted or is expected to last 12 months or more or result in death? If no, the client is ineligible for MA. If yes, the analysis continues to Step 3. 20 CFR 416.920(c).

3. Does the impairment appear on a special listing of impairments or are the client's symptoms, signs, and laboratory findings at least equivalent in severity to the set of medical findings specified for the listed impairment? If no, the analysis continues to Step 4. If yes, MA is approved. 20 CFR 416.290(d).

4. Can the client do the former work that he/she performed within the last 15 years? If yes, the client is ineligible for MA. If no, the analysis continues to Step 5. 20 CFR 416.920(e).

5. Does the client have the Residual Functional Capacity (RFC) to perform other work according to the guidelines set forth at 20 CFR 404, Subpart P, Appendix 2, Sections 200.00-204.00? If yes, the analysis ends and the client is ineligible for MA. If no, MA is approved. 20 CFR 416.920(f).

At Step 1, Petitioner is not engaged in substantial gainful activity and has not worked in recent years. Petitioner is not disqualified from receiving disability at Step 1.

The subjective and objective medical evidence on the record indicates:

Petitioner testified: he is single with no children. He has no income but received Food Assistance Program and Medical Assistance Program benefits. He has a driver's license and drives two times per week to community mental health appointments. He cooks in the microwave 3-4x per week. He takes care of his cat and cleans his bedroom. He sweeps and vacuums. He can stand for 10-15 minutes, sit for 30 minutes and walk 500 feet. He cannot squat or bend at the waist. He cannot tie his shoes nor touch his toes. The heaviest weight he can carry is 15 pounds. He watches television eight hours per day.

This Administrative Law Judge did consider the entire record in making this decision.

Medical documentation indicates a non-severe condition:

A January 4, 2021, report indicates that Petitioner is assessed with peripheral vascular disease, other hammer toes (acquired), right foot, congenital pes cavus, right and left foot; idiopathic progressive neuropathy; pressure ulcer and pain in right toes. The necrotic tissue, slough and fibrous tissue was sharply debrided with dermal curette, tissue nipper and 10# blade into subcutaneous tissue. An antibacterial was applied followed by a sterile dressing and the patient was instructed to continue home care. (Petitioner's Exhibit pages 139-140)

A report dated December 29, 2020, indicates that Petitioner's blood pressure was 123/77. Oxygen saturation on room air was 99. His temperature was 98.1-degree Fahrenheit. The fissure on the left heel healed. Petitioner was able to rise in a single motion. No dizziness. No falls. Moderate limitation of ankle strength and range of motion. (Petitioner's Exhibit page 145)

A November 11, 2020, office visit indicates: Patient admits tobacco use. The patient presents today for follow of ulcer. He returns for follow up of chronic ulceration to the right medial hallux with underlying osteomyelitis, the toe becomes painful when the callus builds up too much. He has no history of diabetes but has idiopathic neuropathy and has a history of osteomyelitis on contralateral foot. He presents in surgical shoe as directed. MM Right foot completed 8/2/2020. Completed 5 out of 8 weeks of IV antibiotics per ID until his PICC fell out. He has since gone to a new infectious disease specialist who ordered a bone scan which showed persistent osteomyelitis and he was started on a 4-week course of oral Zyvox, which he began yesterday (11/10/2020). He is considering surgical intervention on right hallux if needed. Denies n/v/f/d/c/sob. Recent arterial doppler results normal. Associated signs and symptoms include: swelling and painful wound. Patient states that the problem in the are occurred as a result of unknown by patient. Duration is months. Patient indicates ambulation worsens condition and shoe pressure worsens condition. Quality of the pain is described by the patient as constant. Severity of condition is moderate. (Petitioner's Exhibit page 166)

An October 28, 2020, office visit indicates: The patient complains of soreness of the thick, discolored, elongated toenails. Admits to history of idiopathic neuropathy. Denies being diabetic. Patient states that the symptoms are due to shoes, pressure, and walking. Duration is years. Onset of symptoms is gradual. The nature of the symptoms are static. Severity of condition is mild. The character of the pain is described as dull. This occurred as a result of no specific action and tenderness. Alleviating and aggravating factors include improved with rest, worse with shoes and worse on palpation. Previous treatment has included none. The patient presents today for follow of ulcer. He returns for follow up of chronic ulceration to the right medial hallux with recurrent abscess-like pain and symptoms and history of underlying osteomyelitis. He has no history of diabetes but has idiopathic neuropathy and history of osteomyelitis on contralateral foot. He presents in work boot rather than the recommended surgical shoe. Previously the pain was so great that his toe had to be anesthetized in order to debride the wound, which would provide short term relief; this occurred weekly despite IV antibiotics. Today the pain and pressure has returned however it is improving overall and his pain is more manageable. MRI Right foot completed 8/2/20202. He was recently undergoing 8 weeks of IV antibiotics per ID however his PICC line had came out and he has not had any antibiotics since then; he has completed 5 of the 8 weeks he was prescribed. He has followed up with a new infectious disease specialist who sent him for a bone scan and he has a follow up appointment with next Wednesday. He is considering surgical intervention on right hallux if needed. Denies n/v/f/d/c/sob. Recent arterial doppler results normal. Associated signs and symptoms include: swelling and painful wound. Patient states that the problem in the are occurred as a result of unknown by patient. Duration is months. Patient indicates ambulation worsens condition and shoe pressure worsens condition. Quality of the pain is described by the patient as constant. Severity of condition is moderate. (Petitioner’s Exhibit page 171)

An October 21, 2020, bone scan reveals Radiographic images shows soft tissue swelling of the right great toe without bony destruction. There is narrowing of both the metatarsophalangeal and interphalangeal joint of the great toe due to osteoarthritis. 8 mm volar calcaneal spurs seen. There is focal increased activity at the left metatarsal phalangeal joint on delayed bone imaging only. Activity is scattered throughout the midfoot of both feet and at the base of the volar surface of the left calcaneus. Radiographs of the left foot demonstrate postsurgical changes of the left metatarsophalangeal joint which correspond to the activity seen in this region- There is also evidence of 86 mm volar calcaneal spur and degenerative spurring of the midfoot. (Petitioner’s Exhibit page 122)

A September 28, 2020, office visit indicates: The patient presents today for follow up of ulcer. He returns for follow up of chronic ulceration to the right medial hallux with recurrent abscess-like pain and symptoms. He has no history of diabetes but has idiopathic neuropathy and history of osteomyelitis on left foot. He presents in surgical shoe. He began presenting a few weeks ago with abscess-like pain and symptoms to the lateral aspect of the right hallux with no obvious communication with the medial ulcer. Previously the pain was so great that his toe had to be anesthetized in order to

debride the wound, which would provide short term relief; this occurred weekly despite IV antibiotics. Today the pain and pressure has returned however it is improving overall and his pain is more manageable. MRI Right foot completed 8/2/20202. He was recently undergoing 8 weeks of IV antibiotics per ID however last week his PICC line came out and he has not had any antibiotics since then. He has completed 5 of the 8 weeks he was prescribed. He was sent to pain management as there is no evident localized reason his wound and toe remain so painful in the presence of his neuropathy. Denies n/v/f/d/c/sob. Associated signs and symptoms include: swelling and painful wound. Patient states that the problem in the are occurred as a result of unknown by patient. Duration is months. Patient indicates ambulation worsens condition and shoe pressure worsens condition. Quality of the pain is described by the patient as constant. Severity of condition is moderate. (Petitioner's Exhibit page 182)

A medical examination report dated September 9, 2020, indicates that Petitioner's temperature was 97.7 degrees Fahrenheit. His heart rate was 94. His blood pressure was 158/91. He was 5'10" tall and weighed 318 lbs. His BMM was 45.63. He was assessed with cellulitis of the great toe of the right foot; stage three pressure injury of the toe of the right foot; and obesity. He was to continue antibiotic treatment. Lungs were clear, heart S1-S2, abdomen was soft and non-tender. (Petitioner's Exhibit pages 1-4)

A September 3, 2020, MRI of the cervical spine indicates spondylitic changes with mild C3-C4, C4-C5, C6-C7 and mild to moderate C5-C6 stenosis. There is moderate left C5-C6 and moderate left C4-C5 foraminal narrowing. Mild reversal normal cervical lordosis suggesting positioning or muscle spasm. (Petitioner's Exhibit page 136)

An August 11, 2020, progress report indicates that Petitioner was diagnosed with acute osteomyelitis of the right ankle and foot. (Petitioner's Exhibit page 25)

An August 6, 2020, report reveals:

Constitutional (Brief): Obese, but appears stated age, well nourished, well developed and in no acute distress. **Eyes (Brief):** The sclera, conjunctiva and eyelids normal bilaterally and eyelids normal bilaterally.
ENT (Brief): ENT: The ears and nose overall appearance were normal with no scars, lesions or masses. Hearing grossly normal. The inspection shows normal gums, lips, palate, and teeth.
Head and Face (Brief): Head and Face: The examination of the face including the facial bones was within normal limits.
Neck (Brief): Neck and Thyroid: There was no elevation of the jugular-venous pulsation. Trachea Midline. **Lymphatics (Brief):** Lymphatics: The posterior cervical and anterior cervical nodes were normal in size and not tender.
Respiratory (Brief): Pulmonary: No respiratory distress, clear bilateral breath sounds and normal respiratory rhythm and effort.
Cardiovascular (Brief): Cardiovascular: Abnormal capillary refill, but heart rate and rhythm were normal, no murmurs, no gallops, no rubs, no abnormal heart sounds and

normal pedal pulse. Normal carotid pulse bilaterally with no bruit. No varicosities were noted in the extremities. No peripheral edema was noted.
Abdomen (Brief): Abdomen: No hernia was discovered, no abdominal mass palpated, normal bowel sounds, no hepatosplenomegaly, soft and non-tender.
Musculoskeletal (Brief):
Gait/Station: Gait intact and normal station and posture.
Head and Neck: Normal to inspection and palpation and full and painless range of motion of the neck.
Spine/Ribs/Pelvis: No kyphosis, no lordosis, no scoliosis, no tenderness and full and painless range of motion of the spine.
Extremities: No gross deformities noted on upper or lower extremities, normal movements of all extremities.
Digits/Nails: No inflammation and no ischemia.
Skin (Brief): Skin: Swelling and erythema noted directly around wound bed, does not extend to foot, minimal drainage noted when dressing removed. Tenderness with palpation. Warm and dry skin lesions.
Psychiatric (Brief): Psychiatric: Oriented to person, place, and time, the affect was normal, and the mood was normal. (Petitioner's Exhibit page 19)

An August 1, 2020, report indicates that Petitioner has mild chronic compression deformities of T12 and L5. No acute fracture nor lumbar spine. Multilevel Degenerative spondylosis of lumbar spine with moderate central canal stenosis at L3-L4 from disc protrusion with moderate left greater than right foraminal stenosis. Right L5-S1 foraminal stenosis from disc bulge with contact along the existing right L5 nerve root. (Petitioner's Exhibit page 133)

A June 5, 2020, Disability Determination Services decision indicates in the Physical Residual Functional Capacity Assessment that Petitioner has no visual, manipulative, communicative or environmental limitations. He can never crawl, crouch, climb ladders or kneel. He can occasionally balance and climb stairs. No use of foot controls with the right lower extremity. He can occasionally carry 20 lbs., frequently carry 10 pounds, stand or walk about four hours in an eight-hour workday and sit about six hours in an eight-hour workday. (Department's Exhibit pages 30-38)

A [redacted], 2020, progress report from [redacted] indicates that Petitioner works all day doing outdoor carpentry. He had wounds on the tip of the right big toe and medial right big toe. Previous wound to right medial aspect was healed, and distal ulcer was partial thickness. (Petitioner's Exhibit pages 106-109)

A January 25, 2019, radiology report indicates the impression of varus angulation of the right knee with mild lateral subluxation of the right tibia relative to the right femur; severe medial compartment right knee osteoarthritis with degenerative spurring of the right patellofemoral compartment. Small to moderate right knee effusion. (Petitioner's Exhibit pages 127-128)

A December 7, 2018, MRI of the knee indicates: The quadriceps and patellar tendons are normal. CRUCIATES: The anterior cruciate ligament shows edema and likely chronically torn. It is thickened. The posterior cruciate ligament is intact. MENISCI: There is torn degenerated anterior horn of lateral meniscus. The posterior horn of lateral meniscus is normal. There is linear complete tear and degeneration of posterior horn of medial meniscus. There is also partial tear at the root of medial meniscus. Medial knee joint compartment degenerative arthritis.

At Step 2, Petitioner has the burden of proof of establishing that he has a severely restrictive physical or mental impairment that has lasted or is expected to last for the duration of at least 12 months. There is insufficient objective clinical medical evidence in

This Administrative Law Judge finds that Petitioner has reports of pain in multiple areas of his body; however, there are no corresponding clinical findings that support the reports of symptoms and limitations made by Petitioner. There are laboratory or x-ray findings listed in the file. The clinical impression is that Petitioner is stable. There is no medical finding that Petitioner has any muscle atrophy or trauma, abnormality or injury that is consistent with a deteriorating condition. In short, Petitioner has restricted himself from tasks associated with occupational functioning based upon his reports of pain (symptoms) rather than medical findings. Reported symptoms are an insufficient basis upon which a finding that Petitioner has met the evidentiary burden of proof can be made. This Administrative Law Judge finds that the medical record is insufficient to establish that Petitioner has a severely restrictive physical impairment.

Petitioner alleges no disabling mental impairments.

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph (B) of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration; persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). 20 CFR, Part 404, Subpart P, App. 1, 12.00(C).

There is insufficient objective medical/psychiatric evidence in the record indicating Petitioner suffers severe mental limitations. There is a mental residual functional capacity assessment in the record. Petitioner was oriented x3 at all psychiatric evaluations. There is insufficient evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent Petitioner from working at any job. Petitioner was oriented to time, person and place during the hearing. Petitioner was able to answer all of the questions at the hearing and was responsive to the questions. The evidentiary record is insufficient to find that Petitioner suffers a severely restrictive mental impairment. For these reasons, this Administrative Law Judge finds that Petitioner has failed to meet his burden of proof at Step 2. Petitioner must be denied benefits at this step based upon his failure to meet the evidentiary burden.

If Petitioner had not been denied at Step 2, the analysis would proceed to Step 3 where the medical evidence of Petitioner's condition does not give rise to a finding that he would meet a statutory listing in the code of federal regulations.

At Step 3, the medical evidence of Petitioner's condition does not give rise to a finding that Petitioner would meet a statutory listing in the code of federal regulations. This Administrative Law Judge finds that Petitioner's medical record does not support a finding that Petitioner's impairment(s) is a "listed impairment" or equal to a listed impairment. See Appendix 1 of Subpart P of 20 CFR Part 404, Part A.

Listing 1.04, the disorders of the spine was considered and is not supported by medical evidence. Listing 12.04, 12.06 and 12.15 are considered and not supported by medical evidence. Petitioner does not have a compromise of the nerve root, or the spinal cord. He does not have evidence of nerve root compression, atrophy with associate of muscle weakness or muscle weakness. He does not have spinal arachnoiditis ideas which is confirmed by an operative know or pathology report of tissue biopsy.

If Petitioner had not already been denied at Step 2, this Administrative Law Judge would have to deny him again at Step 4 based upon his ability to perform his past relevant work. There is no evidence upon which this Administrative Law Judge could base a finding that Petitioner is unable to perform work in which he has engaged in, in the past. Therefore, if Petitioner had not already been denied at Step 2, he would be denied again at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether Petitioner has the residual functional capacity to perform some other less strenuous tasks than in his prior jobs.

At Step 5, the burden of proof shifts to the Department to establish that Petitioner does not have residual functional capacity.

The residual functional capacity is what an individual can do despite limitations. All impairments will be considered in addition to ability to meet certain demands of jobs in the national economy. Physical demands, mental demands, sensory requirements and other functions will be evaluated. 20 CFR 416.945(a).

To determine the physical demands (exertional requirements) of work in the national economy, we classify jobs as sedentary, light, medium and heavy. These terms have the same meaning as they have in the *Dictionary of Occupational Titles*, published by the Department of Labor. 20 CFR 416.967.

Sedentary work. 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. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if

walking and standing are required occasionally and other sedentary criteria are met. 20 CFR 416.967(a).

Petitioner has submitted insufficient objective medical evidence that he lacks the residual functional capacity to perform some other less strenuous tasks than in his prior employment or that he is physically unable to do sedentary tasks if demanded of him. Petitioner's activities of daily living do not appear to be very limited and he should be able to perform sedentary work even with his impairments. Petitioner has failed to provide the necessary objective medical evidence to establish that he has a severe impairment or combination of impairments which prevent him from performing any level of work for a period of 12 months. Petitioner's testimony as to his limitations indicates that he should be able to perform sedentary work. Thus, he does not currently retain the capacity to perform prior work at Step 4.

The Administrative Law Judge will continue to proceed through the sequential evaluation process to determine whether or not claimant has the residual functional capacity to perform some other less strenuous tasks than in his prior jobs.

At Step 5, the burden of proof shifts to the department to establish that claimant does not have residual functional capacity.

There is insufficient objective medical/psychiatric evidence contained in the file of depression or a cognitive dysfunction that is so severe that it would prevent Petitioner from working at any job. Petitioner was able to answer all the questions at the hearing and was responsive to the questions. Petitioner was oriented to time, person and place during the hearing. Petitioner's complaints of pain, while profound and credible, are out of proportion to the objective medical evidence contained in the file as it relates to Petitioner's ability to perform work. Therefore, this Administrative Law Judge finds that the objective medical evidence on the record does not establish that Petitioner has no residual functional capacity. Petitioner is disqualified from receiving disability at Step 5 based upon the fact that he has not established by objective medical evidence that he cannot perform sedentary work even with his impairments. **Under the Medical-Vocational guidelines a younger person (age 47), high school education and an unskilled work history who is limited to sedentary or light work is not considered disabled.**

Careful consideration has been given to Petitioner's allegations and symptoms. Petitioner has established that his physical and mental condition could cause problems with daily and work functioning. However, the totality of the evidence does not support total disability. Petitioner's medically determinable impairments could reasonably be expected to produce alleged symptoms, but Petitioner's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible when compared to the limitations suggested by the objective medical evidence contained in the file.

The Department's Program Eligibility Manual contains the following policy statements and instructions for caseworkers regarding the State Disability Assistance program: to receive State Disability Assistance, a person must be disabled, caring for a disabled person or age 65 or older. BEM, Item 261, p. 1. Because Petitioner does not meet the definition of disabled under the MA based upon disability and because the evidence of record does not establish that Petitioner is unable to work for a period exceeding 90 days, Petitioner does not meet the disability criteria for SDA benefits.

The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that Petitioner was not eligible to receive State Disability Assistance based upon disability.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the Department has appropriately established on the record that it was acting in compliance with department policy when it denied Petitioner's application for State Disability Assistance benefits. Petitioner should be able to perform a wide range of sedentary work even with his impairments. The Department has established its case by a preponderance of the evidence.

Accordingly, the Department's decision is **AFFIRMED** based upon the substantive information contained in the file.

LL/hb

Landis Lain
Administrative Law Judge
for Elizabeth Hertel, 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

Lapeer County via electronic mail

BSC2 via electronic mail

L. Karadsheh via electronic mail

Petitioner

[redacted]
MI [redacted]

Authorized Hearing Rep.

[redacted]
[redacted], MI [redacted]