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Date Mailed: September 29, 2021
MOAHR Docket No.: 21-002729
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 July 29, 2021, from Detroit, Michigan. Petitioner appeared for the hearing with his father/Authorized Hearing Representative (AHR), [redacted] The Department of Health and Human Services (Department) was represented by Princess Ogundipe, Eligibility Specialist.

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 (20 pages total) which were received, marked, and admitted into evidence as Exhibit 1. The record was subsequently closed on September 1, 2021, 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] 2021, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability. (Exhibit A, pp. 8-14)

2. On or around May 25, 2021, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. (Exhibit A, pp. 25-42)

3. On or around May 27, 2021, the Department sent Petitioner a Notice of Case Action denying his SDA application based on DDS' finding that he was not disabled. (Exhibit A, pp. 4-7)

4. On June 8, 2021, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application. (Exhibit A, p. 3)

5. Petitioner alleged nonexertional/mental disabling impairments due to seizures/epilepsy, paranoia, anxiety, bipolar disorder, depression, schizoaffective disorder, and attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD). Petitioner confirmed that he did not have any alleged physical or exertional impairments.

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

7. Petitioner obtained a General Education Development (GED) diploma and has reported employment history of limited work in food service and as a cashier at a [redacted] and at most, one week as a trainee in fast food restaurants and grocery store. (Exhibit A, pp. 15-21, 79)

8. Petitioner has a pending disability claim with the Social Security Administration (SSA).

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Health and Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 2017), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for SSI purposes requires the application of a five step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual

functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step One

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, he is not ineligible 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 mental health treatment with [redacted] from [redacted] 2020 through May 2021 were presented and reviewed. (Exhibit A, pp. 96-177). Records indicate that Petitioner was being treated for diagnosis of schizoaffective disorder, bipolar type; panic disorder (episodic paroxysmal anxiety) without agoraphobia; ADHD, predominantly inattentive type; social phobia; and bipolar II disorder. On or around [redacted] 2020, Petitioner underwent a psychiatric diagnostic evaluation. It was noted that this was his second attempt at therapy services through the [redacted] and that he first participated from [redacted] 2018, through [redacted] 2019, with diagnosis of Bipolar II disorder and ADHD hyperactive type. After closing his therapy services, Petitioner continued to attend medication review sessions with [redacted] Petitioner was previously taking Xanax and Adderall XR but now prescribed Valium, Adderall, and Trileptal. He reported using marijuana to stay calm and that he has been unemployed for the last three years. Petitioner mentioned having behavior problems when he was in the fifth grade, getting in trouble and fighting often. He dropped out of school before he finished the ninth grade and reported that all of the medication he was taking was not allowing him to concentrate on his assignments. He further reported that he had previously been hospitalized on several occasions with self-destructive ideations and behavior, and that his first hospitalization was at age [redacted] at [redacted] along with a more recent hospitalization at [redacted] in the [redacted] of 2017. In between that time, Petitioner reported additional hospitalizations at [redacted] and [redacted] and

indicated that he has been prescribed various medications, including Risperdal, trazodone, Abilify, and Depakote. He reported suffering from depression, paranoia, and feelings that people were talking about him even when they were not looking at him. He mentioned that his home environment was chaotic and that he was not talking to his mother or father about his problems. In this current episode of treatment, Petitioner reported that he continued to have trouble at home and stated that everyone around him was a psychopath and loser. He reported that the people out in the street were listening to his conversations and that he returned for additional therapy services because he was experiencing a high level of anxiety that was not allowing him to work and have a normal life. Mental status exam showed that Petitioner had fluctuating alertness with respect to his level of consciousness. His mood was anxious, affect intense, his speech was hesitant, his recent and remote memory were not impaired and there was a mild degree of conceptual disorganization. His thought content was characterized by significant preoccupations about anxiety and although he denied hallucinations, Petitioner reported delusional thinking. He verbalized partial awareness of problems as regards to his insight, and his attention/concentration was distractible. Petitioner's thought process was delusional, and he had paranoid thinking, along with impulsive reactions. It was noted that Petitioner had mild psychosis with delusional paranoid thinking. Cognitive behavioral therapy was recommended as was therapy, and medication management. (Exhibit A, pp. 96 – 99). A progress note from Petitioner's psychotherapy appointment on [redacted] 2021 indicates that Petitioner continued to talk about people observing him when he goes out into the street. He thinks that somebody is paying them to bother him just by observing him walking in the street. In addition to lacking money, Petitioner's attention problems and anxiety do not allow him to attend college classes. His cognitive focus was digressive, and he had difficulty seeing alternative perspectives as his paranoid ideations impacted his cognitive flexibility. During a medication review session on [redacted] 2021, Petitioner reported that the phenobarbital is making him cognitively foggy during the day and lethargic. He reported increased feelings of anxiousness and paranoia but indicated he is not feeling as depressed. The doctor assessed Petitioner's mental status as follows: Petitioner's level of consciousness was lethargic, his mood anxious, his speech logical, coherent, and goal directed, his recent and remote memory were not impaired, there was negligible degree of conceptual disorganization evident, his thought content was characterized by preoccupation with his anxiety. Regarding perceptual functioning, Petitioner denied hallucinations, and none were evident during the appointment. His judgment was impaired by anxiety and mood factors. Petitioner's medications were adjusted during this appointment. On [redacted] 2021, Petitioner reported that his medication has caused him to feel fatigued and nauseous as he continues to struggle with anxiety. His mood has been good, his focus fair with the use of Adderall, and no other health concerns identified. Petitioner's mental status was assessed as being similar to that of his [redacted] 2021 medication review appointment. On [redacted] 2021, Petitioner reported to his treating psychiatrist that his anxiety is high, and his mood is mildly depressed and irritable. He indicated that the Seroquel is helping him sleep better but has not improved his anxiety and depression. During a medication review appointment on [redacted] 2021, Petitioner reported his sleep has been poor and that he is concerned about starting his Seroquel medication as he will lack energy and motivation. Petitioner's

mood was mildly depressed, mildly anxious, and mildly irritable. There were no impairments in his recent or remote memory, and a negligible degree of conceptual disorganization was evident. Petitioner's thought process was characterized by a preoccupation with his anxiety and pain problems, trouble with sleep, and attention as well. He denied hallucinations and verbalized a partial awareness of his problems from sleep perspective. Although his judgment was impaired at times by anxiety and mood factors, his attention/concentration is characterized by an ability to attend and maintain focus. On [redacted] 2021, Petitioner continued to report a depressed mood and continued to be somewhat anxious and irritable. On [redacted] 2021, Petitioner reported to his psychiatrist that he continues to be anxious about going to the grocery store and inside the pharmacy. At times, his anxiety gets more intense and he has panic attacks. On [redacted] 2020, Petitioner reported that he ran out of his benzodiazepines and did not refill, afterwards he had a seizure and went to the hospital. While at the hospital, he reported that he was prescribed phenobarbital. It was noted that Petitioner suffers from Reynaud's symptoms and discussed possible treatment options. During that appointment, Petitioner's thought content was characterized by delusions of persecution. On [redacted] 2020, Petitioner raised concerns about going out in public and how he is anxious and feels uncomfortable around people. He reported that he feels he is being watched and stalked. Petitioner indicated that people may be interested in stalking him because of his interest in conspiracy research and the fact that he does not have a job and wants to get disability. On [redacted] 2020, Petitioner reported that he continues to be anxious and reports being followed when he is out running errands. He indicated that he feels he may be targeted for refusing to conform with society and seeking disability payments. He thinks government agents are following him for these reasons. He also reported that when he is playing online gaming, he feels that he is being spied on and thinks that he sees the same usernames over and over again and that these individuals are online to follow him. The doctor discussed the possibility of Petitioner taking antipsychotic medications. Petitioner reported that his mood is moderately depressed, and that he is chronically anxious and paranoid at the time of his [redacted] 2020, medication review appointment. Records from Petitioner's medication review during the period of [redacted] 2020 through [redacted] 2020 show that Petitioner continued to report symptoms associated with depression, anxiety, and paranoia when out in public. He also has side effects of medications and records suggests that adjustments to his medications were often made. (Exhibit A, pp. 96-177).

[redacted] medical records documenting Petitioner's treatment at various facilities were presented and reviewed. (Exhibit A, pp. 180-311). On [redacted] 2020, Petitioner presented to the [redacted] Hospital emergency department with complaints of seizure when waking up that morning. Notes indicate he has a history of alcohol abuse, but Petitioner reported that he has been alcohol free for two weeks. He reportedly ran out of his benzodiazepines days ago and complained of nausea, anxiety, tremors and myalgias. Petitioner indicated that he woke up that morning with his hands over his head feeling numb and stiff. There was no loss of control of bowel or bladder, and no bites on his tongue. Petitioner admitted suffering from seizures in the past due to alcohol abuse/withdrawal. A 12 lead ECG and yielded normal findings. Petitioner was discharged following no concerning results of an ultrasound of the

abdomen and instructed to follow up with his primary care physician. Petitioner was seen at the [redacted] clinic in [redacted] Michigan on [redacted] 2020, for a follow-up of his hand pain. Records indicate Petitioner had an injury to his left wrist in 2016 that continues to cause pain. He stated there is a bulge in his wrist where the fracture healed, and he was referred to multiple providers but is afraid of needles, so he did not show up to his most recent appointment for an injection. Notes indicate that Petitioner refused injections, and desired narcotic pain medications but was told these cannot be mixed with his current medications. Petitioner was diagnosed with tendinitis of the wrist and given a referral for occupational therapy. On [redacted] 2020, Petitioner presented to the [redacted] Hospital emergency department via EMS after suffering what sounded like a mild seizure. Petitioner reported that he has been binge drinking lately and stated that he felt out of it for about an hour, so his parents called 911. He denied biting his tongue or urinating and stated that he normally takes Valium if this happens, but he was too out of it to do that. Petitioner reported that he has not had a breakthrough seizure in approximately one year. Petitioner was discharged in stable condition. (Exhibit A, pp. 180-311).

On or around [redacted] 2017, Petitioner underwent a consultative psychological evaluation. Records from [redacted] Hospital and [redacted] were reviewed and documented diagnosis of mood disorder, and major depressive disorder. Petitioner had submitted documentation alleging he suffered from major depressive disorder, anxiety, obsessive compulsive disorder, manic, and bipolar disorder. He reported that he started taking medication in the sixth grade and at that time, started cutting because he was sad. He admitted that he responded to conflict in his life through self-harming behaviors like cutting but denied suicidal ideation, intent, or plan. The totality of the information provided was suggestive to the evaluator of borderline personality disorder with depression and anxiety. Records indicate Petitioner participated in inpatient mental health treatment in [redacted] 2017 and currently participates in mental health treatment through [redacted]. A mental status exam was completed and diagnosis of borderline personality disorder, and major depressive disorder recurrent episodes with anxious distress were made. The medical source statement indicates that Petitioner's mental disorder impairs his ability to work effectively with supervisors or coworkers. The Petitioner was found able to understand and remember instructions, locations and work like procedures. It was also noted that he is able to stay on task, focus and complete tasks accurately, as well as respond appropriately to changes in work setting based on his adequate insight and judgment. (Exhibit A, pp. 316 – 321)

Petitioner was admitted to [redacted] for inpatient psychiatric treatment on [redacted] 2015, and was discharged on [redacted] 2015. Petitioner was 18 years old at the time of admission and was transported to the emergency department by police, who were dispatched to his home after receiving a report that Petitioner was going to hang himself. Petitioner reported feeling depressed, hopeless, and lonely and indicated this was his third psychiatric hospitalization with the first one being at age 13 for depression. Petitioner confirmed that he cut himself and threatened to kill himself reporting "I kinda felt stuck in life and didn't see a way out." Petitioner was observed to

have numerous superficial self-inflicted scratches to his bilateral arms approximately 5 to 8 inches in length. Petitioner was diagnosed with mood disorder and cluster B personality disorder. Records indicate that Petitioner was admitted to the hospital due to suicidal ideation, self-harm, and mood instability. He was admitted to the adult psychiatry unit and placed on suicide precaution. Through his admission, Petitioner was evaluated by the multidisciplinary team, which included psychiatry, nursing, social work, and occupational therapy. Contact was made with Petitioner's mother, who reported that Petitioner was diagnosed with severe depression at age 12, but the diagnosis was changed to bipolar disorder during a hospitalization in 2014 at [redacted] She reported that there is a history of bipolar disorder in the family and that her father suffers from paranoid schizophrenia. In the days prior to his discharge, Petitioner denied overt suicidal ideations and had no behavioral problems. He was discharged in stable condition and returned home. He was to start a face-to-face program at [redacted] (Exhibit A, pp. 324-355)

An Inpatient Psychiatric Discharge Summary from Petitioner's [redacted] 2014 through [redacted] 2014 treatment with [redacted] was presented and reviewed. Records indicate that Petitioner, who was 16 years old at the time, quit school because of his paranoia. The reason for his admission was suicidal ideations and an attempted overdose on a number of Zoloft pills. Petitioner's discharge diagnosis was major depressive disorder current, severe with psychotic features, generalized anxiety disorder, problems related to education, and cannabis and alcohol use disorder with unknown severity. Significant paranoia was reported, as were symptoms of severe depression. At the time of his discharge, Petitioner denied any suicidal or homicidal ideations, thoughts, or plans. There was no evidence of psychosis and he was clearly able to contract for safety. Petitioner's prognosis was determined to be fair and he was to continue on a medication regimen, as well as outpatient treatment for medication management and therapy. He was also to abstain from the use of nonprescribed mood altering chemicals. While admitted for treatment, Petitioner underwent a psychiatric evaluation on [redacted] 2014. Petitioner reported feelings of guilt, hopelessness, and anhedonia. He reported that he has not been regularly taking his prescribed medication and admitted to a history of cutting, reported significant problems with anxiety, often worries about details and suffers from muscle tension, he indicated that he cannot relax and stated that he worries about all sorts of things whether it be school or home related. Significant paranoia was noted and he recently reported having problems wondering if people are out to get him and being in large groups reportedly freaked him out. Records indicate that petitioner had previously been hospitalized one time for suicidal ideations and has a long history of cutting. Although he denied cutting recently, it was documented that Petitioner had 25 shallow cuts to his right thigh. Mental status examination showed that Petitioner's orientation was full, his speech limited, and he was not cooperative throughout the evaluation. He was noted to have a blunted affect, depressed mood, and linear thought processes. His thought content included suicidal thinking but no homicidal thoughts. There was some paranoia, but no perceptual disturbances. Petitioner's judgment and insight report and his attention, concentration, and memory were marginal. His prognosis was guarded, and he was admitted for a 5-to-7-day inpatient treatment. (Exhibit A, pp. 356-363)

In response to the Interim Order, Petitioner submitted what appear to be discharge instructions/progress notes dated [redacted] 2021, from an admission on [redacted] 2021. It was unclear after review of the documents submitted whether Petitioner was admitted for treatment on [redacted], 2021, and released on [redacted] 2021, as the progress notes were incomplete. The documents refer to a crisis intervention plan and indicate that Petitioner is to continue follow up services with the [redacted] (Exhibit 1)

Petitioner submitted a DHS-49-D Psychiatric/Psychological Examination Report (Report), completed by his treating mental health provider at the [redacted] on [redacted] 2021. The Report indicates that Petitioner was first evaluated by the provider in [redacted] 2018 and that his most recent visit was [redacted] 2021. Petitioner participates in individual therapy and medication management services by a psychiatrist. The Report indicates that Petitioner has a long history of anxiety, depression, bipolar disorder and that his high anxiety and paranoid ideation do not allow for Petitioner to stay in a job for long. Mental Status Examination notes show that Petitioner suffers from delusional thinking, poor attention and concentration, limited common sense, paranoid ideations and auditory hallucinations. The Report indicates that Petitioner spends almost all of his time at home in his room feeling scared about leaving the house. Petitioner's Axis I diagnosis was schizoaffective disorder and social phobia. (Exhibit 1)

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 and the listing criteria applicable at the time of Petitioner's application date, listings 11.02 (epilepsy), 12.03 (schizophrenia spectrum and other psychotic disorders), 12.04 (depressive, bipolar and related disorders), 12.06 (anxiety and obsessive compulsive disorders), 12.08 (personality and impulse control disorders), and 12.11 (neurodevelopmental 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 confirmed that he has no exertional or physical limitations and that he alleges mainly nonexertional mental limitations due to his impairments. He testified that he has been diagnosed with and receiving treatment for bipolar disorder, schizoaffective disorder, anxiety, paranoia, depression, and manic symptoms for several years. He reported that he has been receiving treatment at the [redacted] for three years and that he attends treatment every other week. Petitioner testified that he has been admitted to the hospital for inpatient psychiatric treatment five times due to suicidal ideations, cutting, and overdose. Records dating back to 2014 confirm Petitioner's testimony. Petitioner testified that he suffers from paranoia and hallucinations that people are watching him and talking about him. As a result, he avoids crowds. He testified that he is very depressed and get suicidal thoughts of paranoia that every noise he hears is directed at him. He reported difficulty focusing and that he suffers from anxiety attacks constantly, which consists of symptoms of his heart racing, sweating, loss of focus, and suicidal feelings. He stated that if he is out in public, he can only focus for five minutes. He testified that he has difficulty with short-term memory and forgets what he is talking about minutes later. Petitioner testified that his anger issues are verbal and can get physical. He testified that he has thoughts of hurting himself if he feels he is provoked, and his thoughts are uncontrollable. Petitioner testified that he has auditory and visual hallucinations, mainly paranoia about others watching him and talking about him. He testified that he suffers from suicidal ideations and frequently resorts to cutting himself. Petitioner testified that he has very limited social interaction, as his paranoia does not allow him to be around others in public or even online. Petitioner testified that he was admitted for inpatient psychiatric services in 2015 after ingesting an entire bottle of Zoloft. He testified that in the last few years, he has been drinking alcohol and mixing it with medications in hopes that it would kill him.

Petitioner testified that he hopes he dies in his sleep. He further stated that he has suffered from seizures since 2017, most recently six months prior to the hearing. Since 2017, Petitioner reported that he has had 4 to 5 seizures with EMS being called twice. Petitioner reported that while he does not require assistance with walking, he doesn't feel comfortable or safe going out in public and that he crashed a car on the expressway because he was rushing due to his paranoia. Petitioner testified that while he does not need assistance with bathing or personal hygiene, he doesn't feel comfortable with other people in the home while he is showering due to his inability to defend himself. Petitioner reported that he sometimes is able to mow the lawn, but not if anyone is outside. Petitioner testified that he needs assistance with shopping, as he feels he is being targeted and followed and trapped in the aisles. His parents helped him in order to prevent him from generating rage as he does not want to hurt anybody. Petitioner testified that he used to play video games but his paranoia makes him feel unsafe online and he reported that he does not want to be a target.

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 records documenting his history since childhood of mental health treatment including inpatient psychiatric hospitalizations, suicidal ideations and attempts, delusional thinking, poor attention and concentration, limited common sense, paranoid ideations and auditory hallucinations, among other symptoms, as well as Petitioner's testimony, Petitioner has moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; and in his ability to concentrate, persist, or maintain pace. He has mild limitations in his 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 limited work in food service and as a cashier at a [redacted] and at most, one week as a trainee in fast food restaurants and grocery store which can be classified as requiring light exertion. (Exhibit A, pp. 15-21,79). Based on the RFC analysis above, Petitioner has no limitations to his exertional RFC. Because Petitioner has no exertional limitations, he is not precluded from performing past relevant work due to the exertional requirement of his prior employment. However, his nonexertional RFC results in moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; and in his ability to concentrate, persist, or maintain pace and mild limitations in his ability to adapt or manage oneself. Petitioner's nonexertional RFC would prevent him from being able to perform past relevant work. Therefore, Petitioner cannot be found disabled, or not disabled, at Step 4 and the assessment continues to Step 5.

Step Five

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, if the impairment(s) and related symptoms, such as pain, only affect the ability to perform the non-exertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. 20 CFR 416.969a(c)(2).

In this case, Petitioner has only nonexertional limitations due to his mental condition. Therefore, the Medical-Vocational Guidelines are not relevant in determining whether he can adjust to other work. As discussed above, Petitioner's nonexertional RFC results in moderate to marked limitations in his ability to understand, remember, or apply information; to interact with others; and in his ability to concentrate, persist, or maintain pace and mild limitations in his 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 his 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 SDA determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Reregister and process Petitioner's [redacted] 2021, 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 SDA eligibility in May 2022.

Zainab Baydoun

ZB/jm

Zainab A. Baydoun
Administrative Law Judge

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-Wayne-18-Hearings
BSC4-HearingDecisions
L. Karadsheh
MOAHR

Authorized Hearing Rep. – Via USPS:

[redacted]
MI [redacted]

Petitioner – Via USPS:

[redacted]
[redacted], MI [redacted]