



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS  
DIRECTOR

████████████████████  
██  
██████████, MI ██████████

Date Mailed: June 6, 2022  
MOAHR Docket No.: 22-002007  
Agency No.: ██████████  
Petitioner: ██████████

**ADMINISTRATIVE LAW JUDGE: Ellen McLemore**

**HEARING DECISION**

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on June 1, 2022, from Detroit, Michigan. Petitioner was present with his brother's significant other, ██████████. The Department of Health and Human Services (Department) was represented by Darlean Shaw, Eligibility Specialist.

**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 ██████████, 2021, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.
2. On January 31, 2022, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.
3. On February 7, 2022, the Department sent Petitioner a Notice of Case Action informing him that his SDA application was denied.
4. On ██████████, 2022, Petitioner submitted a timely written Request for Hearing disputing the Department's decision to deny his SDA application.
5. Petitioner alleged disabling impairments due to major depressive disorder with psychotic features. At the hearing, Petitioner also stated he had limitations due to chronic ankle pain.

6. As of the hearing date, Petitioner was ■ years old with a ■■■■■, 1970 date of birth.
7. Petitioner completed the 10<sup>th</sup> grade and was enrolled in special education classes. Petitioner has a reported employment history of work as a dishwasher. Petitioner has reportedly not been employed since August 2015.
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, for 90 or more days. 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). The duration requirement for purposes of SDA eligibility is 90 or more days. BEM 261 (April 2017), p. 2.

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 was thoroughly reviewed and is briefly summarized below:

On [REDACTED] 2021, Petitioner presented for a general health appointment with chief complaints of right wrist and left ankle pain (Exhibit A, pp. 81-85). Petitioner was positive for Finkelstein's test and had decreased range of motion of dorsiflexion in his left ankle. Petitioner was advised to use naproxen and a wrist splint for his wrist, with physical therapy if needed. Petitioner was notified he needed physical therapy for his ankle pain.

On [REDACTED], 2021, Petitioner presented for a general health appointment with a chief complaint of headaches (Exhibit A, pp. 77-80). Petitioner stated he had a severe headaches and recurring headaches. Petitioner reported he had never been diagnosed with migraines but has had headaches since childhood. Petitioner's headaches were frontal to occipital and there was no photophobia or phonophobia. Petitioner did have dizziness and lightheadedness. Petitioner had a normal neurological examination. Petitioner's physician recommended treatment with Toradol and Fioricet, if needed. Petitioner was advised to follow up on or around [REDACTED] 2021.

On [REDACTED], 2021, Petitioner presented for a general health appointment with chief complaints of headaches and dizziness (Exhibit A, pp. 72-76). Petitioner reported he was having photophobia and phonophobia, nausea, and vision changes. Petitioner stated he was compliant with the medications previously prescribed. Petitioner was ordered to switch medication to Topamax. Petitioner also had additional imaging performed (Exhibit A, pp. 86-91). Petitioner had a computed tomography angiography (CTA) scan of his head and neck, which was unremarkable. Petitioner had computerized tomography (CT) scan of his brain, which was unremarkable. Petitioner was diagnosed with headaches, dizziness, diplopia. Diagnoses that were ruled out included migraine; transient ischemic attack; brain hemorrhaging; and cerebellar dysfunction. Petitioner was advised to continue his medication.

On [REDACTED] 2022, Petitioner was admitted to the emergency department, with a discharge date of [REDACTED], 2022 (Exhibit A, pp. 96-271). Petitioner presented with worsening headaches and visual changes. Petitioner indicated he was having headaches three times per week. Petitioner indicated he was waking from sleep and the headaches would last several hours. Petitioner was positive for photophobia; phonophobia; diplopia; and ataxia. Petitioner indicated that his headaches were increasing in frequency and intensity from the previous month. Petitioner also reported that his depressive symptoms were increasing, due to the severity of the headaches. Petitioner stated he had a plan to kill himself with a gun. Petitioner reported no previous suicide attempts. Petitioner indicated he had not been in therapy or taking any psychiatric medications. Petitioner's treating physicians concurred with the diagnosis completed by Petitioner's primary care physician. Petitioner reported symptoms consistent with diplopia and ataxia, but all of his examinations were negative. Petitioner's CT/CTA of his neck was normal, and he had no history of falls or trauma. The examinations of all of Petitioner's other systems were normal. Petitioner was referred to a neurology consultation and possible magnetic resonance imaging (MRI). Petitioner also had a psychiatric evaluation. Petitioner reported feeling severely depressed, overwhelmed, tired, having a lack of energy/motivation, lack of interest in doing things, frustration and having suicidal thoughts. Petitioner was advised to remain hospitalized for in-patient treatment. Petitioner stabilized over the course of his admission. Petitioner was diagnosed with major depressive disorder with psychotic symptoms. Petitioner was advised to follow-up with a psychiatrist.

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 assessment date, listing 12.04 (depressive, bipolar and related disorders) was 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 alleges exertional and nonexertional limitations due to his impairments. Petitioner testified that due to his ankle pain, he primarily walks with the assistance of a cane. Petitioner stated he can sit for long periods of time but gets fidgety. Petitioner testified he could not stand for long periods of time and could only walk a few steps without the assistance of his cane. Petitioner indicated he could lift 30 to 40 pounds and could bend/squat, but not all the way down. Petitioner reported he could ascend and descend stairs if he takes his time. Petitioner indicated he is able to perform his own personal hygiene and chores.

Petitioner testified that he has symptoms of depression but is not seeking any medical treatment. Petitioner stated he is not seeing a therapist, psychiatrist and is not taking any medications. Petitioner reported he has anxiety attacks two to three times per week. Petitioner stated that during an anxiety attack, he has trouble breathing and talking. Petitioner reported difficulties with concentration, memory and frustration. Petitioner stated he does not have anger issues or suicidal thoughts. Petitioner reported that he sometimes sees things that are not there, and it causes him to be fearful. Petitioner stated he does not have any other diagnoses other than depression. Petitioner also indicated that he cannot read or write and has difficulty with comprehension. Petitioner stated that he cannot understand basic directions, which prohibits him from working.

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. A thorough review of Petitioner's medical records, including records presented from Petitioner's treating physicians, was completed. Petitioner only provided medical records for a single examination related to his ankle pain. The record indicates that Petitioner has some decreased range of motion, and that physical therapy was recommended. Petitioner testified he has not engaged in physical therapy.

Petitioner continued to report struggles with symptoms of depression. The majority of Petitioner's medical records relate to Petitioner's frequent headaches. Per the medical records provided, Petitioner reported that his depression symptoms were related to his headaches. At the hearing, Petitioner testified that he no longer has headaches but still has symptoms of depression. Petitioner did not provide any medical evidence related to a diagnosis or treatment of depression outside the emergency room admission in [REDACTED] 2021. During Petitioner's last examination prior to his discharge from the emergency department on [REDACTED], 2021 (Exhibit A, p. 266), he had fair personal hygiene and good eye contact. Petitioner denied suicidal and homicidal ideations. Petitioner denied any auditory and visual hallucinations. Petitioner had no delusion. Petitioner was alert and oriented. Petitioner's speech was nonspontaneous, coherent, goal-directed, productive, with adequate reaction time. Petitioner had normal memory, fair concentration, fair abstraction ability, fair insight, fair judgment, fair impulse control, adequate general knowledge, and adequate intelligence. Petitioner did admit to previous auditory hallucinations and suicidal ideations. Petitioner reported he is not seeking treatment for his current symptoms of depression. Petitioner also did not submit any medical evidence supporting his assertion that he is illiterate. Per the medical records provided, Petitioner was deemed to have adequate intelligence.

Due to Petitioner's physical limitations, he was unable to stand for long periods, had some difficulty walking, squatting and bending. Petitioner had some pain, but it could be managed with prescribed and over-the-counter medication. Petitioner reported he could lift 30 to 40 pounds. There was no indication in the medical records that Petitioner had significant limited mobility. With respect to Petitioner's exertional limitations, it is found based on a review of the entire record, that Petitioner maintains the physical capacity to perform medium work as defined by 20 CFR 416.967(a).

Based on the medical records presented, as well as Petitioner's testimony, Petitioner has: mild limitations with respect to his ability to understand, remember, or apply information; mild limitations with respect to his ability to interact with others; mild limitations in his ability to concentrate, persist, or maintain pace; and mild limitations in his ability to adapt or manage oneself. Thus, Petitioner has mild limitations on his nonexertional ability to perform basic work activities.



Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

**Step Four**

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

Petitioner's work history in the 15 years prior to the application consists of work as a dishwasher. Petitioner's employment as a dishwasher is defined by the Dictionary of Occupational Titles as requiring medium work. Petitioner had no other work history. Therefore, Petitioner's past employment requires medium work.

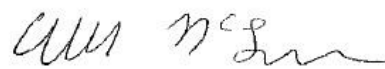
Based on the RFC analysis above, Petitioner's exertional RFC limits him to medium work activities. Therefore, Petitioner is not precluded from performing past relevant work due to the exertional requirements of his prior employment. Additionally, as stated above, Petitioner has a nonexertional RFC imposing only mild limitations in his nonexertional ability to perform basic work. Because Petitioner's nonexertional limitations were mild, they would not preclude him from performing medium work activities on a sustained basis.

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

**DECISION AND ORDER**

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner **not disabled** for purposes of the SDA benefit program.

Accordingly, the Department's determination is **AFFIRMED**.



---

**Ellen McLemore**  
Administrative Law Judge

EM/tm

