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Date Mailed: August 10, 2023
MOAHR Docket No.: 23-003834
Agency No.: [redacted]
Petitioner: [redacted]

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 August 3, 2023, via conference line. Petitioner was present and was unrepresented. The Department of Health and Human Services (Department) was represented by Ryan Reisig, 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 or around February 14, 2023, Petitioner submitted an application for cash assistance on the basis of a disability.

2. On or around June 29, 2023, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program. The DDS determined that Petitioner was capable of performing other work.

3. On July 2, 2023, the Department sent Petitioner a Notice of Case Action denying her SDA application based on DDS' finding that she was not disabled.

4. On July 10, 2023, Petitioner submitted a written Request for Hearing disputing the Department's denial of her SDA application.

5. Petitioner alleged disabling impairments due to depression/bipolar, spinal fractures, anxiety and learning disabilities, including dyslexia.

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1998 date of birth; she was [redacted] and weighed [redacted] pounds.

7. Petitioner dropped out of high school in [redacted]th grade and reported that she is currently working to obtain her GED. Petitioner reported employment history of work at a hotel (housekeeping and desk duties) and working on a line at a flour company. Petitioner has not been employed since December 2022.

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, she is not ineligible under Step 1, and the analysis continues to Step 2.

Step Two

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the de minimis standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen*, 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28. If such a finding is not clearly established by medical evidence or if the effect of an impairment or combination of impairments on the individual's ability to do basic work activities cannot be clearly determined, adjudication must continue through the sequential evaluation process. Id.; SSR 96-3p.

The medical evidence presented at the hearing was thoroughly reviewed and is briefly summarized below.

On [redacted] 2021, Petitioner was admitted at Blanchard Valley Hospital as a result of a car accident (Exhibit A, pp. 117-239). Petitioner arrived via emergency medical services (EMS) and was screaming that she had pain all over her body. Petitioner was noted to have mid thoracic and mid lumbar spine tenderness. Petitioner had a computerized tomography (CT) scan and medical resonance imaging (MRI). Petitioner had an acute burst fracture involving the L1 vertebral body with moderate to marked loss of vertebral height and bony retropulsion along the posterior aspect of L1. Petitioner had severe central narrowing and compression of the anteroposterior dimension of the distal cord and conus at the level of L1 vertebral body related to bony retropulsion. Petitioner had increased T2 signal in the cord and conus, including the interior aspect of T12 and T12-L1 level. Petitioner had mild acute superior endplate compression fracture at T12. Petitioner had discogenic change in the lumbar spine with mild facet entropy. Petitioner had no central stenosis otherwise in the thoracic or lumbar spine. Petitioner reported that she was high on crystal methamphetamine during the accident. Petitioner reported a history of methamphetamine, marijuana and alcohol use. Petitioner's toxicology report showed she was positive for methamphetamine and opiates. Petitioner had surgery including a laminectomy fixation fusion of the T11-L3 and a transpedicular subtotal corpectomy of the L1. Petitioner was discharged on March 11, 2021. Petitioner reported she continued to have hip and back pain.

Petitioner was also under the care of Dr. Arun Gupta, a physician who specializes in the treatment of addiction. Exhibit A, pp. (517-213). On [redacted], 2021, Petitioner had an intake appointment and reported that she had been in a car accident and was currently prescribed oxycodone. Petitioner was diagnosed with cellulitis of the back, obesity, nicotine dependence and a contusion of the hip. Petitioner's surgical wound was treated, including the removal of her staples. Petitioner was advised to complete her antibiotic regimen. On [redacted], 2021, Petitioner had a wellness visit. Petitioner was

advised to exercise and maintain a healthy diet. Petitioner was counseled on smoking cessation. On [redacted], 2021, Petitioner had a follow-up examination. Petitioner presented with primary complaint of back pain and inquired about the suboxone program. Petitioner reported that she wanted to stop using narcotics and signed an Opioid Treatment Contract, agreeing to close medical monitoring. Petitioner was also required to seek counseling. The remainder of Petitioner's staples were removed from her surgery. Petitioner was positive for amphetamine, methamphetamine, morphine, oxycodone, fentanyl, tramadol, and cocaine. On [redacted], 2021, Petitioner had a follow-up examination. Petitioner complained that she had a hole in her back and that she was having issues with her left knee. An x-ray of Petitioner's knee was reviewed from Petitioner's hospitalization, which was negative. Petitioner had an examination on [redacted], 2021. Petitioner reported that she had cyst on her back that was causing her a lot of pain. Petitioner was advised to see a specialist to remove the cyst on her back. Petitioner was positive for amphetamine, methamphetamine, morphine, oxycodone, fentanyl, tramadol, and cocaine. Petitioner had an examination on [redacted], 2022. Petitioner had complaints of a stuffy nose and sore throat. Petitioner had an examination on [redacted], 2022. Petitioner still had complaints of a stuffy nose and sore throat. On [redacted], 2022, Petitioner presented for suboxone program induction. Petitioner's other prescribed medications included Depakote, treatment for bipolar disorder, and Ondansetron, an anti-nausea medication. Petitioner was awake, alert, oriented to time place in person, and well nourished. On a scale of 0 (not at all) to 4 (extremely), Petitioner reported that she was a Level 3 for feeling anxious and desire to use drugs. Petitioner was prescribed suboxone and was advised to take her medications as prescribed. On [redacted] 2022, Petitioner had a wellness exam. Petitioner had no gross swelling, no deformity, no joint pain, no test tenderness during her musculoskeletal exam. Petitioner reported that she had last used more than a week ago and was having cravings. Petitioner presented for a follow-up treatment for her substance abuse treatment program on [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted] 2022; [redacted] 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted] 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted], 2022; [redacted] 2022; and [redacted], 2022. Petitioner maintained her successful opioid treatment and consistently reported no to low feelings of anxiety and the need to use. Petitioner indicated that she believed her overall withdrawal level was a success.

Petitioner was also receiving behavioral health treatment at Family Medical Center of Michigan (Exhibit A, pp. 204-529). On [redacted], 2021, Petitioner had an intake appointment and a behavioral health assessment. Petitioner was diagnosed with generalized anxiety. Petitioner reported that she has struggled with drug and alcohol abuse since she was [redacted] years old. Petitioner stated that she has had symptoms of anxiety for as long as she can remember. Petitioner stated she had been sober but relapsed in [redacted] 2021. Petitioner reported that she was in a residential treatment center for 90 days and was looking to establish psychiatry services and medication management. Petitioner was dressed appropriately, had good hygiene, maintained good eye contact and exhibited cognition expected for her age and developmental level. Petitioner's prescribed medications included sertraline and Abilify. Petitioner's next

appointment was [redacted], 2022, where she reported mood instability. Petitioner indicated she had daily mood swings of irritability, verbal aggression with obscenities, and feelings of rage that lasted up to 45 minutes, ending with crying, sadness, isolation and withdrawal. Petitioner had daily mixed depression, sadness, low mood, low motivation, poor hygiene and lack of interests. Petitioner reported feelings of anxiety and restlessness, racing thoughts, feeling trapped in crowds. Petitioner was diagnosed with bipolar disorder. Petitioner was prescribed Lamictal, a medication to prevent extreme mood swings for bipolar disorder. On [redacted], 2022, Petitioner had an appointment for opioid dependence. Petitioner was prescribed suboxone, Narcan and Sublocade. Petitioner presented for Sublocade injections on [redacted], 2022; [redacted], 2022; and [redacted], 2022. On [redacted], 2022, Petitioner had an appointment to discuss medications. Petitioner was alert and oriented and had adequate hygiene. Petitioner's attention and concertation were intact, but her judgement was impaired. Petitioner had low mood and was eager for treatment. Petitioner had logical thought, was goal directed, had adequate insight and her abstract thought was intact. Petitioner had no delusions. Petitioner was prescribed clonidine, an antihypertensive medication. Petitioner had follow-up appointments for Sublocade injections on [redacted], 2022; [redacted], 2022; [redacted] 2023, [redacted] 27, 2023; [redacted], 2023; [redacted] 2023; [redacted], 2023; and [redacted] 2023. On [redacted], 2023, Petitioner's concentration was intact, but her judgment was impaired. Petitioner was relaxed, sober and cooperative. Petitioner was alert and oriented, with adequate hygiene. Petitioner had no noted compulsions or manic behaviors. Petitioner had appropriate history, logical thought, was goal directed and her abstract though was intact. Petitioner had no delusions. Petitioner reported that her medications were helping, and she was feeling less depressed. Petitioner was now sober with less nightmares. Petitioner indicated she was sleeping and eating well.

Records from Petitioner's high school were presented and reviewed. Petitioner was enrolled in the special education program and had an Individualized Education Program (IEP). On [redacted] 2014, Petitioner had her final IEP evaluation while she was in [redacted]th grade. Petitioner had a long history of special education and difficulty performing at grade level. Petitioner had a reading level grad equivalent of 4.7, and mathematics grad equivalent of 5.8 and the writing skills of a 2-3 grader. Petitioner demonstrated a pattern of emotional and behavioral challenges that limited her functioning. At that time Petitioner had only obtained 3 to 5 credits toward graduating high school. It was indicated that with Petitioner's deficient basic skills, she was unable to plan with the general curriculum in regard to transitioning out of high school.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listings 1.17 (reconstructive surgery of weight bearing joint); 12.04 (depressive, bipolar and related disorders); 12.05 (intellectual disorder); and 12.06 (anxiety and obsessive-compulsive 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 alleges exertional and nonexertional limitations due to her impairments. Petitioner testified that prior to the car accident, she could stand for long periods of time, up to 10 hours. Petitioner reported that she can no longer stand for long periods and can only stand for up to 10 minutes. Petitioner testified that she uses a non-prescribed back brace to help with walking but can only walk 10 feet at a time. Petitioner stated that she can sit for 10 to 20 minutes and can only lift two pounds. Petitioner stated that she can ascend and descend stairs with assistance. Petitioner resides in a group home where food is prepared on her behalf. Petitioner stated that she is not

required to perform chores and rarely leaves the facility. Petitioner reported that she has little to no social interaction and spends most of her time in her room while lying in bed.

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 her symptoms. Petitioner's statements were partially consistent with the medical records. Petitioner's testimony that she sustained an injury to her spine was corroborated by the medical records. However, the majority of the medical records presented were related to Petitioner's addiction treatment. Petitioner was not receiving any treatment from an orthopedist, receiving pain management treatment or completing any physical therapy that would provide further insight as to her limitations. There was some evidence that Petitioner continued to have back pain shortly after her surgery but there was very little documentation in regard to Petitioner's ongoing treatment of her spinal issues. Due to a lack of evidence regarding Petitioner's functional capacity regarding the injury and upon review of the records presented from Petitioner's treating physicians, with respect to Petitioner's exertional limitations, it is found that Petitioner maintains the physical capacity to perform light work as defined by 20 CFR 416.967(a).

Petitioner testified that she has a history of depression and anxiety. Petitioner was diagnosed with bipolar disorder. Petitioner indicated she has difficulty with concentration and memory. Petitioner stated she has anxiety attacks one to two times per week. Petitioner reported she has angry outbursts followed by crying spells on a daily basis. Petitioner testified that her medications were helping, and her mood was starting to improve. Petitioner stated that she also finds employment difficult at times due to her cognitive delay. Petitioner testified that she is a hands-on learner. At the hearing, Petitioner was able to answer the questions asked by the undersigned ALJ, with some difficulty recalling dates of incidents.

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

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 line worker and housekeeper at a hotel, which included cleaning and working at the front desk. Petitioner's employment as a line worker is defined by the Dictionary of Occupational Titles as requiring medium work. As a housekeeper, Petitioner's employment as a retail office associate is classified as requiring light work. Therefore, Petitioner's past employment requires light to medium work.

Based on the RFC analysis above, Petitioner's exertional RFC limits her to light work activities. Therefore, Petitioner is not precluded from performing past relevant work due to the exertional requirements of her prior employment. Additionally, as stated above, Petitioner has a nonexertional RFC imposing mild to marked limitations in her nonexertional ability to perform basic work. Petitioner had some emotional limitations but per the medical evidence provided, her mood was improved by her prescribed medications. Petitioner also had a learning disability, but it is not so significant that it would preclude her from performing unskilled work. Therefore, Petitioner's nonexertional limitations do not preclude her from doing past work 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**.

EM/tm

Ellen McLemore
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-Electronic Mail :

DHHS
Pam Farnsworth
Monroe County DHHS
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Interested Parties
L. Karadsheh
BSC4

Via-First Class Mail :

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