



Date Mailed: August 20, 2025

Docket No.: 25-019788

Case No.: [REDACTED]

Petitioner: [REDACTED]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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[REDACTED]
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[REDACTED], MI [REDACTED]

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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; 42 CFR 438.400 to 438.424; and 45 CFR 205.10. After due notice, a telephone hearing was held on July 21, 2025, from Detroit, Michigan. Petitioner appeared for the hearing and represented herself. The Department of Health and Human Services (Department) was represented by Zelia Cobb, Medical Contact Worker.

Exhibit A, pp. 1-751 was admitted into the record as evidence on behalf of the Department.

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] 2024, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability.
2. On or around May 22, 2025, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program.
3. On or around May 23, 2025, the Department sent Petitioner a Notice of Case Action, denying her SDA application based on DDS' finding that she was not disabled.
4. On or around May 27, 2025, Petitioner submitted a timely written Request for Hearing disputing the Department's denial of her SDA application.
5. In connection with the application, Petitioner alleged disabling impairments due to back and knee pain, bipolar disorder with psychotic features, panic disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), insomnia, agoraphobia, schizophrenia, and epilepsy.

25-019788

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6. As of the hearing date, Petitioner was ■ years old with a ■■■■■■■■■■, 1989, date of birth. She was ■ and weighed ■ pounds.
 7. Petitioner completed the 10th grade. Petitioner did not obtain a high school diploma or General Education Development (GED) diploma.
 8. Petitioner is not currently employed. Petitioner has reported employment history in the last five years of work as a black jack dealer for an online company, a laborer at a car part factory, and a teacher assistant at a daycare. Petitioner was reportedly last employed in 2022..
 9. 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 Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180. A person is considered disabled for SDA purposes if the person has a physical or mental impairment which meets federal Supplemental Security Income (SSI) disability standards for at least ninety days. Receipt of SSI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness, automatically qualifies an individual as disabled for purposes of the SDA program.

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

25-019788

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 416.922(b).

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.

The medical evidence presented at the hearing was reviewed and, in consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, it is found to be 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.

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

On or around ██████████ 2024, Petitioner appeared for a disability assessment examination, where her medical records were reviewed. Petitioner was noted to have bipolar disorder, PTSD, chronic low back pain since 2019 that she identified was a 10/10 on the pain scale, left knee pain, pain of the left ankle joint, mild persistent asthma, and schizophrenia. It is noted that during the assessment, Petitioner described chronic low back pain and knee pain as well as bilateral hand pain and left shoulder pain that were not identified as alleged impairments in connection with her current ██████████ 2024, SDA application. The medical source statement indicates that Petitioner has daily physical limitations due to ongoing current chronic health conditions, that she cannot arise from a squatting position and cannot squat. She can dress, undress, get on and off the exam table and stand on heels and toes. The Petitioner used crutches and a walker to ambulate due to an abnormally slow gait. (Exhibit A, pp. 135-139)

On or around ██████████ 2024, Petitioner had a follow-up appointment for her left knee pain and back pain at DMC Grand River Health Center. Petitioner reported her left knee pain has been going on for many years, that it is sharp in nature, with no radiations, and a 9/10 in intensity. Petitioner further reported that she has spasms in the lumbar region of her back since her motor vehicle accident. Records indicate that Petitioner was being treated for bipolar disorder and schizophrenia. Petitioner reported diagnosis of epilepsy

25-019788

with her last seizure occurring in 2022. A referral was made for Petitioner to participate in physical therapy. Records documenting Petitioner's 2023 visits to DMC Grand River Health Center were also reviewed. (Exhibit A, pp. 140- 148, 523-559)

On or around May 6, 2025, Petitioner was referred by the state disability office for an internal medicine examination with allegations of schizophrenia, bipolar disorder, obsessive-compulsive disorder, PTSD, depression, anxiety, epilepsy, sleep disorder, back pain, ankle pain, and shoulder pain. Chronic pain, mental health issues and seizure were also noted. Petitioner reported that she has diabetes mellitus but is not on any treatment and does not take her medication. She reported that she was diagnosed in 2025. Petitioner stated that she had recent pain in the sternum and left chest pain that feels sharp but which may not be suggestive of angina pectoris caused by anxiety and at random. The chest pain occurs on average three times per week and lasts for approximately one minute. A referral to cardiology was indicated. Petitioner presented with a history of bilateral shoulder pain with an onset date of 2005. She described the pain as aching and radiating to the hand with a pain level of 10 out of 10. She reported that the pain is exacerbated by activities and dislocation and relieved by rest. She also reported a history of bilateral feet pain with an onset date of 2023 which she described as aching and numbing. The pain is made worse by standing and walking and relieved by rest. History of lumbar pain with an onset date of 2019 following a motor vehicle accident was described as aching and sharp, and radiating up her back with a pain level of 10 out of 10 being worse. The pain is made worse by activities and bending and standing and relieved by medication and rest. Petitioner had history of depression and anxiety, bipolar disorder PTSD and schizophrenia but reported that she has never been hospitalized for mental health issues. Petitioner reported one previous suicide attempt as a minor. Petitioner reported currently taking medications for her mental condition for the last three years. Petitioner reported that her mental condition affects her ability to work, as she is triggered by the way people talk to her resulting in leaving the job. Petitioner reported a history of seizures and seizure disorder diagnosed in 2019 with her most recent seizure occurring in 2022. It is noted that Petitioner was a poor historian. With respect to the activities of daily living, Petitioner was reported to live alone, able to dress herself, able to shower or bathe daily but unable to cook or prepare meals, clean, do laundry, and go shopping due to pain. Petitioner reported that she is assisted by her caretaker. Petitioner appeared to be in no acute distress throughout the examination. Her gait was normal and she was able to walk on her toes and heels without difficulty. Squat was 25% and she used no assistive device to ambulate. She was able to get up and out of the chair without difficulty, as well as on and off the examination table without difficulty. She did not require any assistance with changing for the exam. Petitioner's motor strength was noted to be five out of five in the upper and lower extremities. Her grip strength was 4/5 on the right-hand and on the left, was 5/5 and she was able to button, tie, and zip on the left without difficulty. Range of motion was not full in all extremities of the spine. Cervical spine was within normal limits. Lumbar spine had the following range of motion: forward flexion 80°, extension 25°, lateral flexion of the right 20° and left 25°, rotation of the right 20° and left 20°. Range of motion to the shoulders, elbows, wrists, hip, and ankles were within normal limits. Knee flexion of the right and

25-019788

left was 145° and extension of the right and left was 0°. Petitioner's prognosis was noted to be fair as she had mild limitations walking, standing, and climbing stairs. She had mild-to-moderate limitations with bending, mild limitations kneeling, crawling, crouching, and moderate limitations with squatting. She had mild limitations with lifting and carrying with both hands and mild-to-moderate limitations for grasping with the right hand. Petitioner had mild limitations reaching overhead with both hands and should avoid exposure to smoke, dust, and other respiratory irritants as well as heights and operating heavy machinery and activities where she and others could be injured if they had to be driving. X rays of the lumbosacral spine left shoulder, and left ankle were ordered. (Exhibit A, pp. 354-364)

Results of X ray of the left shoulder completed on [REDACTED], 2025, showed no acute fracture or dislocation was seen, joint spaces were preserved, the bone mineralization was within normal limits and the soft tissues were intact. There was no acute osseous abnormality. Results of x-ray to the left ankle showed the same findings and impression. X-ray of the lumbar spine showed no acute fractures or subluxations, the vertebral body heights were maintained and alignment preserved, bone mineralization is within normal limits and the soft tissues were intact. There was no acute osseous abnormality. (Exhibit A, pp. 365-367)

On or around [REDACTED], 2025, Petitioner presented to the physical medicine and rehabilitation clinic for an initial evaluation with reports of low back pain and bilateral foot pain and numbness. She reported that she does not feel pain shooting from her back, down her legs, but she does experience bilateral foot numbness and tingling. Secondly, Petitioner has noticed swelling and temperature changes in feet and reported that the pain in her back started in 2019 following a motor vehicle accident. Petitioner's pain was described as sharp, aching, and tingling with numbness. She reported that it interferes with her activities of daily living and rated her pain as a 10/10 in severity. The impression was that Petitioner had lumbar degenerative disc disease, lumbar spinal stenosis, and bilateral lumbar radiculopathy. An MRI of the lumbar spine was ordered and Petitioner was prescribed medications.(Exhibit A, pp. 397-404)

Records from Petitioner's 2023-2024 mental health treatment with Lincoln Behavioral Services were presented and reviewed. Psychiatric Progress Notes indicate that Petitioner was receiving treatment for diagnosis of bipolar one disorder with psychotic features, panic disorder, generalized anxiety disorder, posttraumatic stress disorder, among other conditions. Throughout the course of her treatment, Petitioner reported frequent panic attacks, racing thoughts and paranoia, poor sleep and appetite with lack of concentration, as well as anxiety around crowds and driving/leaving home. During an [REDACTED], 2023 appointment, Petitioner reported that she goes consecutive days without sleep. She denied suicidal ideations. Petitioner reported seeing dark shadowed figures that are fast, animal figures and that she has been using prayer to try to get the visual hallucinations to go away. She reported extreme paranoia and delusions and feels like something is crawling on her skin. Mood swings and anxiety with racing thoughts as well as feelings of sluggish and inability to complete tasks were also noted.

25-019788

On [REDACTED], 2023, Petitioner participated in an initial psychiatric evaluation. Petitioner reported that she has seen a psychiatrist in the past and received a diagnosis of bipolar disorder. She reported feeling depressed and down, hopeless and helpless, and expressed that she has crying spells with feelings of guilt. She reported that her memory is poor, and her focus is sporadic. She reported that her anxiety was bad. She gets panic attacks with lots of worry and is easily overwhelmed. She reported having mood swings and racing thoughts. She indicated that she gets easily angry and is unable to finish a project when she starts one. She reported that in the past, she used to cut herself but not recently. Petitioner reported that she gets flashbacks of being raped and physical trauma from when she was beaten up. During a [REDACTED], 2023, integrated bio psychosocial assessment, Petitioner reported that she was referred by her primary care doctor and reported that she experiences anxiety and isolates herself. She states that she is easily frustrated with people and this is affecting her ability to maintain a job. She experiences drastic mood swings and reported having visual hallucinations but perceives them as premonitions, and they are not bothersome to her as she reported that she has had them all her life. Petitioner reported no current suicidal ideations and that her last suicidal thought was in 2022. Petitioner reported hearing voices and seeing visions including shadows of people when she was around 11 years of age. (Exhibit A, pp. 561- 641)

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 1.15 (disorders of the skeletal spine resulting in compromise of a nerve root), 1.16 (lumbar spinal stenosis resulting in compromise of the cauda equina), 1.18 (abnormality of a major joint(s) in any extremity), 3.03 (asthma), 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 12.15 (trauma and stressor related 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). Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality are considered. 20 CFR 416.920a(c)(1). 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. In connection with her application, Petitioner completed a function report detailing how her illnesses or conditions limit her daily activities. (Exhibit A, pp. 123-133). Petitioner's testimony during the hearing was fairly consistent with the information she provided in her functional report. Petitioner testified she suffers from back and knee pain that prevents her from walking more than one block at a time. Petitioner testified that she uses a cane to assist with walking but indicated that it does not help her pain very much. Petitioner testified that she is able to sit for one hour due to her back pain and that she is able to stand for a limited amount of time. Petitioner is unable to squat due to her knee pain. Petitioner asserted that she is able to lift no more than 5 pounds. Petitioner reported that she lives alone and her friend comes over to her home every day because she cannot complete any long tasks. While Petitioner indicated that she can bathe herself and care for her own personal hygiene, she is unable to perform any household chores. Petitioner testified that her friend performs most of her household chores and prepares her meals. Petitioner testified that she does not use a stove due to her fears and paranoia surrounding fires. She requires assistance with shopping and stated that she does not like to leave the house due to paranoid thoughts of something bad happening to herself or someone else.

With respect to her mental impairments, Petitioner testified that she was diagnosed with bipolar manic depression, PTSD, social anxiety disorder, schizophrenia/panic disorder,

25-019788

agoraphobia, anxiety, and depression. Petitioner asserted that she receives treatment from a therapist as well as medication management treatment from a psychiatrist. Petitioner testified that she has difficulty focusing, paranoia, trouble with following directions and being yelled at, and suffers from anxiety attacks throughout the day with racing thoughts. Petitioner testified that her mind races with thoughts that something bad is going to happen. She is able to concentrate for only a short period of time and has difficulty remembering dates and appointments. Petitioner testified that she suffers from crying spells that happen out of the blue throughout the day. Petitioner testified that her anger outbursts manifest verbally as well as physically. While Petitioner testified that she does not have any thoughts of hurting herself or others, she does suffer from both visual and auditory hallucinations.

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 testimony as to her exertional impairments related to her back and knee pain are supported by the medical evidence presented for review and document diagnosis of lumbar degenerative disc disease, lumbar spinal stenosis, and bilateral lumbar radiculopathy. Additionally, the consultative examination found limitations with respect to Petitioner's ability to walk, stand, or climb stairs. Based on a thorough review of Petitioner's medical record and in consideration of the reports and records presented from Petitioner's treating physicians, 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 sedentary work as defined by 20 CFR 416.967(a). Petitioner has mild to moderate limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, stooping, or crouching. 20 CFR 416.969a(c)(1)(i)-(vi).

Additionally, records indicate that Petitioner suffers from daily symptoms associated with her mental conditions for which she has been receiving mental health treatment including therapy and medication management. Based on the medical record presented, as well as Petitioner's testimony, Petitioner has moderate to marked limitations in her mental functioning including her ability to understand, remember, or apply information; in her ability to interact with others; in her ability to concentrate, persist, or maintain pace and 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

25-019788

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 5 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1)(i). Work that was started and stopped in fewer than 30 calendar days is not PRW. *Id.* and 20 CFR 416.960(b)(1)(ii). 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 5 years prior to the application consists of employment as a black jack dealer for an online company, a laborer at a car part factory, and a teacher assistant at a daycare. Upon review, Petitioner's past employment is characterized as requiring sedentary to medium exertion. Although based on the RFC analysis above, Petitioner's exertional RFC limits her to sedentary work activities and thus, she is not precluded from performing past relevant work due to the exertional requirement of her prior employment, Petitioner has additional nonexertional and mental limitations noted above that would prevent her from being able to perform past relevant work. Therefore, she cannot be found disabled, or not disabled at Step 4 and the assessment continues to Step 5.

Step 5

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, when a person has a combination of exertional and nonexertional limitations or restrictions, the rules pertaining to the strength limitations provide a framework to guide the disability determination **unless** there is a rule that directs a conclusion that the individual is disabled based upon strength limitations. 20 CFR 416.969a(d).

In this case, Petitioner was ■ years old at the time of application and at the time of hearing, and thus, considered to be a younger individual (age ■) for purposes of Appendix 2. She completed the 10th grade but did not obtain a high school diploma or GED and has unskilled work history. As discussed above, Petitioner maintains the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities. Thus, based solely on her exertional RFC, the Medical-Vocational Guidelines, result in a finding that Petitioner is not disabled. However, as referenced above, Petitioner also has nonexertional impairments imposing additional limitations. Petitioner has mild to moderate limitations on her non-exertional ability to perform basic work activities, with respect to performing manipulative or postural functions of some work such as reaching, handling, bending, stooping, or crouching and moderate to marked limitations in her mental functioning including her ability to understand, remember, or apply information; in her ability to interact with others; in her ability to concentrate, persist, or maintain pace and in her 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 her 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

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.

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. Re-register and process Petitioner's [REDACTED] 2024, 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 from the application date, ongoing; and
3. Review Petitioner's continued SDA eligibility in May 2026.



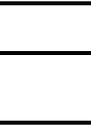
ZAINAB A BAYDOUN
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at <https://lrs.michbar.org> or Michigan Legal Help at <https://michiganlegalhelp.org>. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
Michigan Office of Administrative Hearings and Rules
Rehearing/Reconsideration Request
P.O. Box 30639
Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.



Via
Electronic Mail:

Respondent
WAYNE-GREYDALE-DHHS
27260 PLYMOUTH RD
REDFORD, MI 48239
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Via
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Petitioner
[REDACTED]
[REDACTED]
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