Michigan Office of Administrative Hearings and Rules
P.O. Box 30639
Lansing, MI 48909

Date Mailed: December 2, 2025
Docket No.: 25-022688
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

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

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这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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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; and 45 CFR 205.10. After due notice, a telephone hearing was held on November 13, 2025, via teleconference. Petitioner was present and was unrepresented. The Department was represented by Stephanie Peterson, Assistance Payments Worker.

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 [redacted] 2025, Petitioner submitted an application seeking cash assistance benefits on the basis of a disability (Exhibit A, pp. 8-13).

2. On May 12, 2025, the Disability Determination Service (DDS) found Petitioner not disabled for purposes of the SDA program (Exhibit A, pp. 27-28).

3. On May 13, 2025, the Department sent Petitioner a Notice of Case Action informing him that his SDA application was denied (Exhibit A, pp. 29-32).

4. On June 6, 2025, 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 left sided weakness, as a result of stroke; depression; and bipolar disorder (Exhibit A, pp. 15-21).

6. As of the hearing date, Petitioner was [redacted] years old with a [redacted], 1987 date of birth.

7. Petitioner obtained a high school degree and completed some college credits. Petitioner has a reported employment history as a dishwasher, customer service representative and sales associate. Petitioner has reportedly not been employed since September 2024.

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] 2022, Petitioner presented at [redacted] Department (Exhibit A, pp. 1538-1598). Petitioner reporting feelings of depression, anxiety and suicidal ideations. Petitioner reported that over the previous two to three weeks he had increased drug use. Petitioner had a colostomy bag as a result of previous abdominal surgery due to a gunshot wound to the abdomen. Petitioner had not been managing his care of his colostomy bag. Petitioner was discharged and advised to continue taking Zoloft.

Petitioner was previously seeking general care with his primary care physician (PCP) and psychiatric care through [redacted] (Exhibit A, pp. 1477-1537) prior to having a stroke in September 2024. On [redacted] 2023, Petitioner had a psychiatric evaluation. Petitioner reported that he self-medicated with illicit substances. Petitioner reported a long history of symptoms of post-traumatic stress disorder (PTSD) which had worsened since he was carjacked and shot. Petitioner reported a history of trauma due to parental physical abuse. Petitioner indicated he had flashbacks, nightmares, fatigue, anhedonia, excessive worry, feeling on edge, restlessness, overeating and frequent night waking. Petitioner also acknowledged he had suicidal ideations. Petitioner indicated he wanted to seek substance abuse treatment. Petitioner had psychiatric follow up appointments on March 20, 2023, and on October 6, 2023, Petitioner presented with symptoms of mania, depression and suicidal ideations. Petitioner was referred to triage. Petitioner was diagnosed with PTSD, cocaine dependence and alcohol dependence. On February 10, 2023, Petitioner had an appointment with his PCP. Petitioner was diagnosed with uncontrolled diabetes, insomnia and gastroesophageal reflux disease (GERD). Petitioner was prescribed amoxicillin, an antibiotic; aripiprazole, an antipsychotic; atorvastatin, a statin for high cholesterol and triglyceride levels; benzonatate, a cough suppressant; gabapentin, treatment for nerve pain; mirtazapine, an antidepressant; omeprazole, for stomach acid and polyethylene glycol, a laxative. Petitioner had PCP appointments on July 3, 2023; July 6, 2023; August 21, 2023; February 28, 2024; July 17, 2024; August 8, 2024; August 13, 2024; and August 19, 2024.

Petitioner was previously seeking substance abuse rehabilitative treatment at Hegira Health (Exhibit A, pp. 813-1200). On June 11, 2024, Petitioner indicated substance abuse of alcohol, amphetamines, crack cocaine, methamphetamine. Petitioner reported experiencing cravings, tolerance, withdrawal, attempts to quit/control use and continued use despite consequences. Petitioner reported 15 plus treatment episodes. Petitioner was diagnosed with bipolar disorder with the recent episode was classified as severe. It was recommended Petitioner receive treatment for withdrawal management. Petitioner continued to seek treatment and had follow up appointments on June 14, 2024; July 8, 2024; and July 22, 2024.

Petitioner had a history of admissions at [redacted] (Exhibit A, pp. 1203-1452). On August 19, 2023, Petitioner presented with calf pain as a result of a previous gunshot wound to the area. Petitioner was discharged in stable condition. On June 25, 2024, Petitioner presented with suicidal ideations due to a history of drug use. Petitioner reported he had been discharged from a treatment facility and was feeling depressed, anxious and suicidal. Petitioner was taking Remeron and Abilify prescribed by his primary care physician. Petitioner was prescribed Depakote and was admitted for in-patient psychiatric treatment. Petitioner also reported a history of manic episodes and increased drug use. Petitioner was diagnosed with bipolar disorder, cocaine use disorder and PTSD. Petitioner was discharged on July 1, 2024, and to follow up with psychiatric treatment. On September 22, 2024, Petitioner presented with left side weakness and facial paralysis. A computed tomography (CT) examination was performed which found an area of hypodensity within the right posterior lentiform nucleus extending into the adjacent white matter corresponding to the area of acute infarction. Magnetic resonating imaging (MRI) was also performed which showed maturing infarction involving the right basal ganglia. On September 27, 2024, Petitioner was discharged from the emergency department to seek rehabilitative therapy after his stroke.

Petitioner had numerous admissions to the emergency department at [redacted] (Exhibit A, pp. 418-577). On November 14, 2024, Petitioner presented at the emergency department at Henry Ford Hospital with left-sided pain. Petitioner's left-sided pain was likely due to the previous stroke. Petitioner was given Norco, a lidocaine patch and gabapentin which improved his symptoms. Petitioner was discharged on November 15, 2024, with a referral to psychiatry and psychotherapy. On November 20, 2024, Petitioner arrived at the emergency department at [redacted] with chief complaints of suicidal ideations. Petitioner was admitted to the emergency department. It was determined that Petitioner was a high risk for self-harm. Petitioner had not been seen at Hegira since July 22, 2024. The emergency department did not have any inpatient treatment available for Petitioner. On November 24, 2024, it was noted Petitioner had worsening feelings of depression with suicidal ideation. Petitioner was noted to be standing next to the bed and flexing his left arm independently. On November 25, 2024, Petitioner was discharged with a recommendation to admit him to inpatient behavioral health treatment. On [redacted] 2024, Petitioner arrived at [redacted] emergency department. Petitioner

arrived by emergency medical services due to a slip and fall which caused his colostomy bag to rupture. Petitioner had feelings of depression and suicidal ideations. Petitioner indicated that since his discharge several days prior, he had been binging crack cocaine. Petitioner had not been taking his medications in the few days prior. Petitioner also reported alcohol and tobacco use. Petitioner remained hospitalized. Petitioner continued to report left sided pain. Petitioner engaged in therapeutic and occupation therapy. On December 2, 2024, Petitioner had a physical therapy assessment. Petitioner's gait was limited due to pain and weakness in his left side. Petitioner had an unsteady gait and was determined as a fall risk. On December 3, 2024, Petitioner was discharged with the recommendation to continue his medications and occupational and physical therapy

On February 10, 2025, Petitioner reentered treatment at [redacted] (Exhibit A, pp. 238-242). Petitioner reported he had not gotten "high" since November 12, 2024. Petitioner reported improved relationships with family and friends. Petitioner reported feelings of hopelessness, which prompted hospitalization. Petitioner reported being sober for six weeks and was seeking a referral for co-occurring group/bipolar group to aid in his recovery.

On March 18, 2025, Petitioner had a psychiatric examination related to his claim for social security benefits (Exhibit A, pp. 225-228). Petitioner reported a history of excessive polysubstance abuse including powder, crack cocaine, heroin, methamphetamines, and cannabis dating back to the age of 28. Petitioner reported he was in and out of rehab eight times but had been clean and sober for the previous four months. Petitioner had been psychiatrically hospitalized multiple times dating back to 2016 with the most recent in 2024. Petitioner admitted that he had been using cocaine to self-medicate. Petitioner described himself as bipolar with manic episodes and paranoia in the form of feeling as if other people were plotting against him with no specific delusions. Petitioner had thoughts about dying and feelings of anger, upset and envy due to his limited mobility because of his stroke. Petitioner stated he had feelings of depression. From the examination and reviewing practitioners' previous records, the referral was consistent with polysubstance abuse disorder in very early remission, as well as substance induced mood disorder and a mild learning disability. It was the examining practitioner's opinion that if Petitioner remained in remission from substance abuse and was compliant with psychiatric medications and supportive counseling, he would be able to follow at least simple routine tasks at a sustained pace.

On March 19, 2025, Petitioner had a physical evaluation related to his claim for social security benefits (Exhibit A, pp. 216-223). Petitioner's constitutional examination revealed he was not in good health. Petitioner's A1C was more than nine and his diabetes was not under control despite using insulin. Petitioner's cardiovascular examination revealed no heart problem, no chest pain and no shortness of breath. Petitioner's head, eyes, ears, nose and throat (HEENT) examination revealed his hearing was normal, no blurred vision, no glaucoma, no hearing loss and no sinus problem. Petitioner's respiratory examination revealed no chronic cough, no shortness

of breath and no asthma. Petitioner's gastrointestinal examination revealed he had GERD and heartburn but no peptic ulcer disease. Petitioner's genitourinary examination revealed no frequency, no dysuria and no history of kidney stones. Petitioner's musculoskeletal examination revealed he had contracture of the left elbow, as well as his left shoulder following hemiplegia from his stroke. Petitioner's skin examination was normal. Petitioner's neurologic examination revealed he had hemiplegia and that he was receiving therapy and recovering from left sided aplasia. Petitioner's endocrine examination revealed he had uncontrolled diabetes mellitus and was currently taking insulin. Petitioner's hematologic examination revealed no history of anemia or phlebitis. Petitioner was assessed to have left-sided stroke affecting both the upper and lower extremities on the left side but had contracture of the left elbow. Petitioner had profound motor deficits in both the left upper and left lower extremities. Petitioner had a permanent colostomy, diabetes, bipolar depression and a history of substance abuse. It was indicated that Petitioner had dependent activities of daily living on his uncle. Petitioner could not bend, stoop carry, button clothing, tie show laces or pick up a pencil with his left side. Petitioner could not squat or climb stairs.

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, listings 11.04 (vascular insult to the brain), 12.04 (depressive, bipolar and related disorders), 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 his impairments. Petitioner testified that due to his stroke, he has extreme weakness in his left side. Petitioner stated that he is able to lift his left arm, but he cannot use his hand to grip or grasp. Petitioner still has functionality of his dominant right arm and hand. Petitioner requires a cane to walk due to his left side weakness and can walk for five-minute periods. Petitioner stated he can only sit for two to three minutes due to spasms, he cannot bend or squat, but he can ascend and descend stairs. Petitioner reported that his vision is not impaired, but he has difficulty reading due to his stroke. Petitioner reported he experiences shooting pain through his fingers, arm and legs. Petitioner reported he is limited in the medication he can take to treat the pain because of his previous addictions.

Petitioner stated that his feelings of anxiety and depression were exacerbated since his stroke because his inability to engage in his previous activities of daily living. Petitioner indicated he has panic attacks around five times per month, crying spells on a weekly basis, feelings of anger and depression. Petitioner reported he has difficulty concentrating and focusing on tasks due to his stroke. Petitioner stated that he does maintain a social life by visiting friends and family. At the time of the hearing, Petitioner was seeking treatment with a mental health therapist as well as an addiction recovery therapist. However, Petitioner did not provide medical records regarding his treatment. Petitioner reported that the medication he is prescribed for his mental health disorders helps, but it is not consistent, as he still experiences feelings of depression.

Petitioner testified that he lives with two other men in a transitional living home and utilizes his brother as a caregiver. Petitioner requires assistance into the shower but can bathe on his own. Petitioner indicated he needs assistance dressing himself as he cannot button or zipper. Petitioner stated he performs some chores such as vacuuming but gets easily short of breath. Petitioner relies on his brother to shop but he can drive.

Petitioner stated he spends his days engaging in physical therapy, attending substance abuse meetings, engaging in therapy, meditation, journaling and occasional walks.

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's most recent physical examination revealed left-sided stroke affecting both the upper and lower extremities on the left side but had contracture of the left elbow. Petitioner had profound motor deficits in both the left upper and left lower extremities. Petitioner had a permanent colostomy, diabetes, bipolar depression and a history of substance abuse. It was indicated that Petitioner had dependent activities of daily living on his uncle. Petitioner could not bend, stoop carry, button clothing, tie show laces or pick up a pencil with his left side. Petitioner could not squat or climb stairs. Petitioner did have complete functionality of his right dominant side.

Petitioner continued to report struggles with symptoms of depression, anxiety, hopelessness, helplessness, dysregulated emotions, low energy, difficulty sleeping and relapsed substance abuse. Petitioner's referral for a psychiatric examination was consistent with polysubstance abuse disorder in very early remission, as well as substance induced mood disorder and a mild learning disability. It was the examining practitioner's opinion that if Petitioner remained in remission from substance abuse and was compliant with psychiatric medications and supportive counseling, he would be able to follow at least simple routine tasks at a sustained pace.

Due to Petitioner's physical limitations, he was unable to sit for long periods, had difficulty walking, squatting and bending. Petitioner reported he had some chronic pain, but there was little medical evidence supporting the assertion. 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).

Based on the medical records presented, as well as Petitioner's testimony, Petitioner has: moderate limitations with respect to his ability to understand, remember, or apply information; mild limitations with respect to his ability to interact with others; moderate 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 to moderate 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 5 years prior to the application consists of work as a customer service representative, sales associate and kitchen worker. Petitioner's employment as a kitchen worker is defined by the Dictionary of Occupational Titles as requiring medium work. Petitioner's history as a retail customer service representative and sales associate required sedentary to light work. Petitioner's history as sales associate required sedentary to light work. Therefore, Petitioner's past employment requires sedentary to light work.

Based on the RFC analysis above, Petitioner's exertional RFC limits him to sedentary work activities. Petitioner's work history includes sedentary work. Petitioner's ability to perform normal sedentary activities is not further eroded, as Petitioner's left sided weakness impacted only his non-dominant side. Petitioner retained full functionality of his dominant right hand and arm. Additionally, Petitioner testified that his past work history included a home office where he performed his work duties on a remote basis. Therefore, Petitioner is not precluded from performing past relevant work due to the exertional requirements of his prior employment.

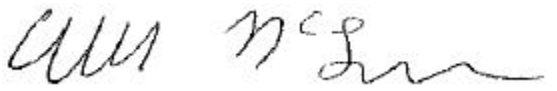
Additionally, as stated above, Petitioner has a nonexertional RFC imposing mild to moderate limitations in his nonexertional ability to perform basic work. The majority of Petitioner's nonexertional limitations were mild or moderate, which would not preclude him from performing sedentary or light activities on a sustained basis. Additionally, during Petitioner's psychiatric examination, it was determined that if Petitioner maintains his sobriety and mental health treatment, he would be able to follow at least simple routine tasks at a sustained pace. Therefore, Petitioner's nonexertional limitations do not preclude him 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.**



ELLEN MCLEMORE
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-TAYLOR-DHHS
25637 ECORSE RD
TAYLOR, MI 48180
MDHHS-WAYNE-18-HEARINGS@MICHIGAN.GOV

Via First Class Mail: **Petitioner**
[redacted]
MI [redacted]