Michigan Office of Administrative Hearings and Rules
P.O. Box 30639
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Date Mailed: November 18, 2025
Docket No.: 25-033823
Case No.: [redacted]
Petitioner: [redacted] [redacted]

[redacted]

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

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HEARING DECISION

On September 23, 2025, Petitioner [redacted] requested a hearing to dispute a State Disability Assistance (SDA) determination. As a result, a hearing was scheduled to be held on November 10, 2025. Public assistance hearings are held pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 42 CFR 438.400 to 438.424; 45 CFR 99.1 to 99.33; 45 CFR 205.10; and Mich Admin Code, R 792.11002.

The parties appeared for the scheduled hearing. Petitioner appeared with his authorized hearing representative, [redacted] Respondent Michigan Department of Health and Human Services (Department) had Hearing Facilitator April Sprague appear as its representative. There were no other participants.

Both parties provided sworn testimony, and two exhibits were admitted into evidence during the hearing. An 828-page packet of documents provided by the Department was admitted collectively as Exhibit A, and a 24-page packet of documents provided by Petitioner was admitted collectively as Exhibit 1.

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. Petitioner's date of birth is December [redacted] 1993.

2. Petitioner lives alone.

3. Petitioner obtained a bachelor's degree in special education from a college in Costa Rica.

4. Petitioner's first language is Spanish.

5. Petitioner is proficient in the English language.

6. Petitioner is right-handed.

7. Petitioner is able to see without any vision correction.

8. Petitioner is able to hear without any hearing correction.

9. Petitioner is able to drive a vehicle, and Petitioner has a current driver's license without any restrictions.

10. Petitioner does not use tobacco products.

11. Petitioner does not use alcohol.

12. Petitioner has a history of using marijuana.

13. Petitioner is able to follow instructions, remember, concentrate, complete tasks, and work with others.

14. Petitioner is able to sit, stand, walk, reach, bend, and climb stairs. However, Petitioner has some difficulty due to pain, and Petitioner must make some physical movements slowly.

15. Petitioner is able to dress, bathe, transfer positions, toilet, and eat on his own.

16. Petitioner is able to manage finances, manage medications, prepare food, clean, and do laundry.

17. Petitioner spends most of his time at home watching television and resting.

18. Petitioner does not use any adaptive medical equipment such as a cane, walker, or wheelchair.

19. From September 2018 to May 2022, Petitioner was employed by [redacted] Petitioner was a full-time substitute teacher. Petitioner taught various classes and after-school programs. Petitioner used a computer, phone, and books to perform his job. Petitioner spent about four of eight hours per day sitting, and Petitioner spent about four of eight hours per day standing. Petitioner sometimes had to lift boxes of paper. The heaviest boxes that Petitioner had to lift weighed 20 to 50 pounds. Petitioner frequently had to lift boxes that weighed 10 pounds. Petitioner held this employment until he quit working at [redacted]. (Exhibit A, pp. 92-98)

20. From September 2022 to April 2024, Petitioner was employed by [redacted] Claimant was a full-time factory production worker. Petitioner trained employees in production positions. Petitioner used a computer, phone, and

manufacturing equipment to perform his job. Petitioner spent all of his time standing or walking. Petitioner had to lift heavy boxes of parts and products. The heaviest boxes that Petitioner had to lift weighed 50 to 100 pounds. Petitioner frequently had to lift boxes that weighed 65 pounds. Petitioner held this employment until he was fired. Petitioner was fired following a physical altercation at work. (Exhibit A, pp. 92-96)

21. Petitioner last worked in December 2024. Petitioner was employed by temporary help firm, and Claimant was assigned to work in a clerical position in an office at a car company. Petitioner obtained information online and completed forms. Petitioner used a computer and printer to perform his job. Petitioner spent about five of eight hours per day sitting, and Petitioner spent about three of eight hours per day standing. Petitioner sometimes had to lift boxes of paper. The heaviest boxes that Petitioner had to lift weighed about 50 pounds. Petitioner frequently had to lift boxes that weighed 25 to 50 pounds. Petitioner held this employment for about one month until the temporary assignment ended. (Exhibit A, pp. 92-94)

22. Petitioner has not tried to work since he held his last job.

23. On June [redacted] 2025, Petitioner applied for state disability cash assistance from the Department.

24. Petitioner completed a medical social questionnaire and submitted it to the Department. (Exhibit A, pp. 33-38). In the medical social questionnaire, Petitioner reported the following pertinent information: the illnesses, injuries, and conditions that limit his ability to work are major depressive disorder, HIV infection, and generalized anxiety disorder. Petitioner stated, “my physical and mental stability has been on the verge of collapse, and I have begun specialist treatment for my recovery.”

25. Petitioner completed a functional report and submitted it to the Department. (Exhibit A, pp. 71-91). In the functional report, Petitioner reported the following pertinent information: Petitioner reported that his illness, injuries, and conditions limit his ability to work by affecting his attendance. Petitioner reported that he suffers from difficulty concentrating, fatigue, headaches, vomiting, and back pain. Petitioner reported that he needs frequent medical appointments.

26. The Disability Determination Service (DDS) reviewed Petitioner’s application together with his medical social questionnaire, his functional report, his work history, and his medical records.

27. Petitioner’s medical records reflected the following pertinent information:

a. On June [redacted] 2024, Integrated Services of Kalamazoo discharged Petitioner from treatment because Petitioner dropped out of treatment. (Exhibit A, pp. 496-499)

b. On August [redacted] 2024, Petitioner met with LLMSW Celeste Corliss at Integrated Services of Kalamazoo for a psychiatric diagnostic evaluation. Petitioner reported that he had been diagnosed with depression and anxiety. Petitioner reported that he ran out of the depression medication that NP Kelsey Knapp had prescribed him. Petitioner requested to speak with NP Knapp. Petitioner expressed a desire to have whole health testing. LLMSW Corliss noted that Petitioner's current prescription medications were Prozac 20 mg once daily and hydroxyzine 25 mg twice daily as needed. LLMSW Corliss noted diagnoses of major depressive disorder and generalized anxiety disorder. LLMSW Corliss determined that Petitioner met the criteria for psychiatric services through Integrated Services of Kalamazoo. LLMSW Corliss referred Petitioner to Integrated Services of Kalamazoo Psychiatric Services. (Exhibit A, pp. 479-495)

c. On August [redacted] 2024, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for a new patient assessment. Petitioner reported that he went through a bad divorce five or six months ago. Petitioner reported that he was having issues with depression. Petitioner reported that he was prescribed hydroxyzine for his anxiety, and Petitioner reported that it worked well. Petitioner reported that he ran out of hydroxyzine and never got a refill. Petitioner reported that he had an appointment with a social worker. Petitioner requested to be checked out for STDs. Dr. Naz noted a diagnosis of major depressive disorder. Dr. Naz prescribed Petitioner Zoloft 50 mg, and Dr. Naz instructed Petitioner to take a half tab at bedtime for three days and then one tab at bedtime thereafter. Dr. Naz ordered STD screening tests. (Exhibit A, pp. 338-339)

d. On August [redacted] 2024, Petitioner visited the emergency department at Bronson Methodist Hospital with a complaint of panic attack. The emergency department gave Petitioner an oral dose of Xanax, and Petitioner began resting comfortably. The emergency department prescribed Petitioner Xanax 0.25 mg three times daily as needed for insomnia. The emergency department counseled Petitioner on mental health and discharged him. (Exhibit A, pp. 333-338)

e. On September [redacted] 2024, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for a follow-up visit. Petitioner had recently been to the emergency department and was following up with Dr. Naz as instructed. Dr. Naz noted a diagnosis of major depressive disorder. Dr. Naz instructed Petitioner to discontinue Zoloft and start vilazodone 10 mg once daily. (Exhibit A, pp. 331-333)

f. On September [redacted] 2024, Petitioner met with Dr. Benjamin Avner at WMED Health Infectious Disease for establishment of care following an HIV diagnosis. Petitioner reported that he was in an abusive relationship with a husband who was HIV positive. Petitioner reported that he learned about his HIV exposure about two years ago, and he has only recently been able to go to a doctor to get an evaluation. Petitioner reported that he was feeling down and totally exhausted a few months ago, but Petitioner reported that his health is very good from a physical standpoint. Petitioner reported that he wanted to get started with treatment for his HIV. Petitioner reported that he recently started taking medication for his mood, and Petitioner reported that his anxiety was more or less controlled now. Petitioner reported that he was a former marijuana user. Dr. Avner prescribed BIC-FTC-TAF medication. (Exhibit A, pp. 198-206)

g. On September [redacted] 2024, Petitioner received an injection of ceftriaxone for HIV. (Exhibit A, p. 326)

h. On September [redacted] 2024, Petitioner met with NP Kelsey Knapp at Integrated Services of Kalamazoo for a medication review. Petitioner requested that NP Knapp review his prescription medications. Petitioner had been prescribed Prozac 20 mg once daily and hydroxyzine 25 mg three times daily as needed. NP Knapp noted that Petitioner should have been out of his medications in May 2024. Petitioner reported that his PCP prescribed him vilazodone 10 mg once daily for his anxiety and depression. Petitioner reported that the hydroxyzine was working. NP Knapp noted diagnoses of major depressive disorder and generalized anxiety disorder. NP Knapp increased Petitioner's vilazodone to 20 mg daily, and NP Knapp instructed Petitioner to continue taking hydroxyzine to 25 mg three times daily as needed. (Exhibit A, pp. 472-478)

i. On September [redacted] 2024, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for a medication follow-up visit. Petitioner reported that he started seeing a psychiatrist, the psychiatrist increased his vilazodone to two pills per day, and Petitioner has been feeling much better. Petitioner also reported that he started seeing an infectious disease provider and he has started treatment for his HIV. Dr. Naz noted a diagnosis of major depressive disorder. (Exhibit A, pp. 324-325)

j. On November [redacted] 2024, Petitioner met with Dr. Benjamin Avner at WMED Health Infectious Disease for a scheduled follow-up visit for HIV. Petitioner reported that he was feeling very poorly. Petitioner reported he recently started suffering from fatigue, diarrhea, and vomiting. Dr. Avner noted that Petitioner had reported similar episodes in the past. Petitioner reported that his episodes started before he started antiretroviral therapy. Dr. Avner

noted a diagnosis of HIV. Dr. Avner noted that he did not think Petitioner's episodes were related to HIV. Dr. Avner counseled Petitioner to go to the emergency department for care. Dr. Avner noted that medication recently established control of Petitioner's HIV. Dr. Avner instructed Petitioner to continue BIC-FTC-TAF medication. Petitioner stated that he would prefer to start an injectable therapy. (Exhibit A, pp. 190-198)

k. On November [redacted] 2024, Petitioner visited the emergency department at Bronson Methodist Hospital with a complaint of emesis. Petitioner reported daily marijuana use. The notes from the emergency department stated, "suspect possible cannabis hyperemesis syndrome versus viral gastroenteritis. Plan for lab work to assess for infection given history of HIV with CBC, CMP lipase UA as well as symptomatic treatment with Toradol and Reglan. On reexamination patient is reporting no symptoms, requesting to go home at this time. Patient denies any abdominal pain or nausea at this time. Discussed cutting back on marijuana use to see if symptoms resolve. . . ." (Exhibit A, pp. 315-319)

l. On November [redacted] 2024, Petitioner met with NP Kelsey Knapp at Integrated Services of Kalamazoo for a medication review. Petitioner requested that NP Knapp review his prescription medications: vilazodone 10 mg once daily and hydroxyzine 25 mg three times daily as needed. Petitioner reported that his anxiety has increased significantly. Petitioner requested increases in his medications to help manage his symptoms. Petitioner reported using marijuana recreationally. NP Knapp noted diagnoses of major depressive disorder and generalized anxiety disorder. NP Knapp increased Petitioner's vilazodone to 40 mg daily, and NP Knapp increased Petitioner's hydroxyzine to 50 mg three times daily as needed. (Exhibit A, pp. 465-471)

m. On November [redacted] 2024, Petitioner received vaccinations for meningococcal, COVID-19, and Hepatitis A and B. (Exhibit A, p. 315)

n. On January [redacted] 2025, Petitioner received his second Hepatitis B vaccination dose. (Exhibit A, p. 314)

o. On March [redacted] 2025, Petitioner met with Dr. Benjamin Avner at WMED Health Infectious Disease for a scheduled follow-up visit for HIV. Petitioner reported that he was not having any problems with his health other than a slight headache that started a few weeks ago. Petitioner reported that he was not suffering any side effects from his medication. Petitioner reported using marijuana. Dr. Avner noted a diagnosis of HIV. Dr. Avner noted that medication recently established control of Petitioner's HIV. Dr. Avner instructed Petitioner to continue BIC-FTC-TAF medication. Dr. Avner discussed an injectable therapy with Petitioner and informed Petitioner that his insurance may not cover it. (Exhibit A, pp. 183-190)

p. On March [redacted] 2025, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for an annual exam. Petitioner reported that he was currently smoking marijuana. Dr. Naz noted a diagnosis of major depressive disorder. Dr. Naz referred Petitioner to psychiatry. Dr. Naz encouraged Petitioner to exercise, eat healthy, and seek dental care. Dr. Naz instructed Petitioner to continue with vilazodone and hydroxyzine for his depression. (Exhibit A, pp. 305-309)

q. On March [redacted] 2025, Petitioner met with MSW Aziza Awad at Taylor Life Center to request case management services. MSW Awad initiated Petitioner's case management services. (Exhibit A, pp. 527-529)

r. On April [redacted] 2025, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for migraines. Petitioner reported that he had been having migraines every three or four days. Petitioner described them as the worst headaches of his life. Petitioner denied that he was having any vision changes. Petitioner reported that he was out of 800 mg Motrin. Petitioner reported that his depression was getting better. Dr. Naz noted diagnoses of chronic non-intractable headache and major depressive disorder. Dr. Naz prescribed Petitioner Motrin 800 mg once every eight hours as needed for his migraines. Dr. Naz ordered a brain MRI. Dr. Naz prescribed Petitioner vilazodone 40 mg once daily and hydroxyzine 50 mg three times daily for his depression. (Exhibit A, pp. 303-304)

s. On April [redacted] 2025, Petitioner met with LBSW Danyelle Barskdale at Taylor Life Center to schedule a time to set up case management services. (Exhibit A, pp. 521-524)

t. On April [redacted] 2025, Petitioner visited the Bronson Infusion Center and received an infusion of cabotegravir-rilpivirine for HIV. (Exhibit A, pp. 301-302)

u. On April [redacted] 2025, Petitioner met with LBSW Danyelle Barskdale at Taylor Life Center to set up case management services. Petitioner expressed that his goal was to be stable with his mental and physical health so that he can begin to move forward with his life. LBSW Barksdale developed a case management plan to coordinate Petitioner's providers as needed, link Petitioner to resources as needed, schedule Petitioner's appointments as needed, monitor Petitioner's mental and physical health monthly, and advocate for Petitioner. (Exhibit A, pp. 514-519)

v. On May [redacted] 2025, Petitioner met with Dr. Shamanthika Shelkay at WMED Health Psychiatry for an initial outpatient psychiatric evaluation for major depressive disorder. Petitioner reported that his ex-husband abused him physically, sexually, and psychologically. Petitioner reported that he was married to his ex-husband for about six years until they got divorced six

months ago. Petitioner reported that he has been feeling angry, frightened, anxious, and panicky. Petitioner reported that he has been having flashbacks of the abuse. Petitioner reported that he was infected with HIV while he was married. Petitioner reported that he has been receiving treatment for his HIV, and Petitioner reported that his HIV is better managed now. Petitioner reported that he sometimes suffers from sweating, upset stomach, numbness and tingling in his hands and arms, trouble sleeping, and nightmares. Petitioner reported using marijuana three times per week. Dr. Shelkay noted a diagnosis of PTSD. Dr. Shelkay prescribed clonidine ER from 0.1 mg at bedtime, and Dr. Shelkay adjusted Petitioner's prescription for hydroxyzine from 50 mg three times a day to 25 mg three times a day as needed. Dr. Shelkay noted that Petitioner will need to pursue therapy for further trauma processing once his symptoms are under better control. Dr. Shelkay also noted that Petitioner will need to stop using marijuana as it will likely worsen his anxiety. (Exhibit A, pp. 170-182)

w. On May [redacted] 2025, Petitioner met with LBSW Danyelle Barskdale at Taylor Life Center to receive case management services. (Exhibit A, pp. 511-513)

x. On May [redacted] 2025, Petitioner met with Dr. Benjamin Avner at WMED Health Infectious Disease for a scheduled follow-up visit for HIV. Dr. Avner noted a diagnosis of HIV. Dr. Avner noted that Petitioner's HIV was well-controlled with medication. Petitioner reported side effects from initial dose of cabotegravir-rilpivirine, but Petitioner reported they settled down, and Petitioner expressed that he was interested in continuing the medication. Dr. Avner noted that Petitioner would continue cabotegravir-rilpivirine. (Exhibit A, pp. 162-169)

y. On May [redacted] 2025, Petitioner visited the emergency department at McLaren hospital with a complaint of nausea, vomiting, and diarrhea. The notes from the emergency department stated, "diagnoses considered include but are not limited to viral gastroenteritis, pancreatitis, colitis, less likely diverticulitis, appendicitis, or cholecystitis. Unremarkable diagnostic studies. The patient received partial improvement after Zofran and morphine, but significantly better improvement of his pain with Bentyl as well." The emergency medical provider prescribed Bentyl and Zofran. (Exhibit A, pp. 209-211)

z. On May [redacted] 2025, Petitioner visited the Bronson Infusion Center and received an infusion of cabotegravir-rilpivirine for HIV. (Exhibit A, pp. 295-296)

aa. On May [redacted] 2025, Petitioner met with LBSW Danyelle Barskdale at Taylor Life Center to receive case management services. (Exhibit A, pp. 508-510)

bb. On May [redacted] 2025, Petitioner met with Dr. Shamanthika Shelkay at WMED Health Psychiatry for medication management. Dr. Shelkay noted a diagnosis of PTSD. Dr. Shelkay adjusted Petitioner's prescription for clonidine ER from 0.1 mg at bedtime to 0.2 mg at bedtime. (Exhibit A, pp. 152-161)

cc. On May [redacted] 2025, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for headaches. Petitioner reported that he had been having headaches every three days. Petitioner reported that it feels like there is a band around his head, he is sensitive to light, and he vomits sometimes. Petitioner reported that he has been taking ibuprofen and Tylenol. Dr. Naz noted a diagnosis of chronic non-intractable headache. Dr. Naz prescribed Petitioner Topamax – 25 mg twice daily. (Exhibit A, pp. 292-293)

dd. On June [redacted] 2025, Petitioner met with Dr. Shamanthika Shelkay at WMED Health Psychiatry for medication management. Dr. Shelkay noted a diagnosis of PTSD. Dr. Shelkay adjusted Petitioner's prescription for clonidine ER from 0.2 mg at bedtime to 0.1 mg twice a day. (Exhibit A, pp. 142-151)

ee. On June [redacted] 2025, Petitioner met with LBSW Danyelle Barskdale at Taylor Life Center to receive case management services. (Exhibit A, pp. 505-507)

ff. On June [redacted] 2025, Petitioner met with Dr. Zebi Naz at Bronson Methodist Hospital for a follow-up visit for headaches. Petitioner reported that he was feeling much better, and Petitioner reported that he has not had any headaches since starting Topamax. Petitioner reported that his psych medications were adjusted recently and that was making him feel better too. Petitioner reported that he still has pain in his right lumbar or flank area. Petitioner reported that he takes Motrin and it helps. Dr. Naz noted diagnoses of chronic non-intractable headache and pain in right lumbar region of back. Dr. Naz instructed Petitioner to continue with Topamax, and Dr. Naz ordered an x-ray of Petitioner's spine lumbar. (Exhibit A, pp. 290-292)

gg. On June [redacted] 2025, Petitioner had an x-ray of his lumbar spine. The exam impression was mild scoliosis - otherwise normal examination. (Exhibit A, pp. 390-391)

hh. On July [redacted] 2025, Petitioner met with NP Amy Conley at Taylor Life Center for a psychiatric evaluation. Petitioner reported that he had depression and anxiety. Petitioner reported that he has panic attacks. Petitioner reported taking Topamax 25 mg twice daily for headaches, vilazodone 40 mg daily for depression/anxiety, clonidine 0.1 mg twice daily, Bentyl 20 mg as needed, hydroxyzine 25 mg three times daily as needed for anxiety, and

Motrin 800 mg for pain. Petitioner reported that he feels like his depression could improve as he lacks energy and motivation. NP Conley noted diagnoses of major depressive disorder and generalized anxiety disorder. NP Conley advised Petitioner to seek psychotherapy. NP Conley prescribed Petitioner mirtazapine 7.5 mg once daily at bedtime as needed. NP Conley instructed Petitioner to continue taking hydroxyzine and vilazodone as prescribed. NP Conley instructed Petitioner to discontinue clonidine. (Exhibit A, pp. 802-811)

ii. On July [redacted] 2025, Petitioner met with PT Colin Seidowski for an initial physical therapy evaluation and treatment plan. PT Seidowski noted a diagnosis of pain in right lumbar region of back and mild scoliosis. PT Seidowski determined that Petitioner would benefit from PT services to improve movement quality, reduce muscular guarding, and improve physical function in ADLs and sleeping. PT Seidowski developed a plan for Petitioner to complete PT twice per week for eight weeks. (Exhibit A, pp. 816-819)

jj. On August [redacted] 2025, Petitioner met with PT Marlon Buenvenida for a physical therapy re-check and treatment. PT Buenvenida noted a diagnosis of pain in right lumbar region of back and mild scoliosis. PT Buenvenida noted that Petitioner had completed eight PT sessions. Petitioner reported that he was in pain and PT was not helping. PT Buenvenida placed Petitioner's PT on hold because Petitioner was not responding well to PT. PT Buenvenida advised Petitioner to return to his PCP for treatment. (Exhibit A, pp. 812-815)

kk. On August [redacted] 2025, Petitioner met with NP Amy Conley at Taylor Life Center for a follow-up visit for medications. Petitioner reported that vilazodone was not working for him. Petitioner reported depression, anxiety, mood instability, and sleep disturbances. Petitioner reported that he is in constant pain, and it contributes to his depression, anxiety, and sleep disturbances. NP Conley noted diagnoses of major depressive disorder and generalized anxiety disorder. NP Conley advised Petitioner to seek psychotherapy. NP Conley decreased Petitioner's vilazodone prescription to 20 mg twice daily for seven days and then to 10 mg once daily for seven days to transition Petitioner to Cymbalta. NP Conley prescribed Petitioner Cymbalta 30 mg once daily for depression/anxiety. (Exhibit 1)

ll. On September [redacted] 2025, Petitioner met with Dr. Rebecca McConnell at Bronson Methodist Hospital for a new patient assessment. Petitioner reported pain in the right side low back from the thoracic to lumbar. Petitioner reported that his pain began following an incident that occurred approximately two and a half years ago. Dr. McConnell did not note a

diagnosis. Dr. McConnell's notes state that mild scoliosis (but likely due to pain positioning, unclear if there is restrictive asymmetry). Dr. McConnell instructed Petitioner to continue gentle exercises and wean off back brace. Dr. McConnell prescribed Petitioner Flexeril as needed. Dr. McConnell ordered a MRI of Petitioner's thoracic and lumbar. (Exhibit A, pp. 820-827)

mm. On September [redacted] 2025, Petitioner met with staff at Taylor Life Center to receive case management services. (Exhibit 1)

nn. On September [redacted] 2025, Petitioner met with staff at Taylor Life Center to receive case management services. (Exhibit 1)

oo. On October [redacted] 2025, Petitioner met with staff at Taylor Life Center to receive case management services. (Exhibit 1)

pp. On October [redacted] 2025, Petitioner met with staff at Taylor Life Center to receive case management services. (Exhibit 1)

qq. On October [redacted] 2025, Petitioner met with NP Amy Conley at Taylor Life Center for a follow-up visit for medications. Petitioner reported that his mood has improved. Petitioner reported that he feels more like himself with the Cymbalta. Petitioner reported that he is feeling more motivated to do things such as cook. Petitioner reported that he has been waking up in the night with anxiety, and he has been taking hydroxyzine with good results. NP Conley noted diagnoses of major depressive disorder and generalized anxiety disorder. NP Conley advised Petitioner to seek psychotherapy. NP Conley noted that Petitioner should abstain from any kind of illicit substances. NP Conley increased Petitioner's Cymbalta prescription to 60 mg once daily. (Exhibit 1)

28. The DDS determined that Petitioner maintained the residual physical capacity to perform medium work. The DDS determined that Petitioner could occasionally lift and/or carry 50 pounds, Petitioner could frequently lift and/or carry 25 pounds, Petitioner could stand and/or walk for a total of about six hours in an eight-hour workday, and Petitioner could sit for a total of about six hours in an eight-hour workday. The DDS determined that Petitioner maintained the mental residual capacity to perform simple/routine tasks on a sustained basis. (Exhibit A, pp. 24-26)

29. On August [redacted] 2025, the DDS determined that Petitioner was not disabled because he was capable of performing other work. (Exhibit A, pp. 13-14)

30. On August [redacted] 2025, the Department issued a notice of case action to Petitioner to notify him that his application for state disability cash assistance was denied. (Exhibit A, pp. 8-11)

31. Petitioner requested a hearing to dispute the Department's determination.

CONCLUSIONS OF LAW

Department policies are contained in DHHS Bridges Administrative Manual (BAM), DHHS Bridges Eligibility Manual (BEM), and DHHS Reference Tables Manual (RFT).

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

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (April 1, 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 benefits based on disability or blindness. *Id.* at 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. *Id.* at 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. *Id.*

In general, the individual alleging a disability 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 has not engaged in SGA during the period at issue. Therefore, Petitioner cannot be assessed as not disabled at Step 1, so the evaluation 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 at 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 Servs*, 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, so the analysis will proceed to Step 3.

Step Three

Step 3 of the sequential analysis of a disability claim requires a determination of whether 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.

Petitioner alleged impairments including back pain, depression, generalized anxiety disorder, PTSD, and HIV. Based on the medical evidence presented in this case, the following listings were considered:

- 1:18 Abnormality of a major joint(s) in any extremity
- 12.04 Depressive, bipolar and related disorders
- 12.06 Anxiety and obsessive-compulsive disorders
- 12.15 Trauma- and stressor-related disorders
- 14.11 Human immunodeficiency virus (HIV) infection

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, so 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, non-exertional, or a combination of both. 20 CFR 416.969a. If an 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 non-exertional 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, assessing the ability to (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). A five-point scale is used to rate the degree of limitation in each area: 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).

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 non-medical sources. SSR 16-3p.

Petitioner alleged impairments including back pain, depression, generalized anxiety disorder, PTSD, and HIV. Accordingly, these are the impairments that will be analyzed.

Petitioner alleged back pain caused him pain, discomfort, and difficulty moving. Back pain is a medically determinable impairment that could reasonably be expected to cause Petitioner's alleged symptoms. Petitioner has sought medical treatment for his back pain. Petitioner's medical providers diagnosed Petitioner with pain in right lumbar region of back and mild scoliosis. One of Petitioner's medical providers noted that Petitioner's mild scoliosis was likely due to pain positioning. Petitioner's medical providers have successfully treated Petitioner's pain with Motrin, but Petitioner continued to complain of symptoms related to his back pain. Petitioner attempted to complete physical therapy, but Petitioner reported that it did not help. Petitioner's back pain is currently being treated with Motrin, Flexeril, and gentle back exercises. Petitioner does not use any adaptive equipment for his mobility. Petitioner stated that his back pain virtually limits all his physical movements all the time. Petitioner's statement about the intensity and limiting effects of his back pain are inconsistent with the evidence presented.

Petitioner alleged mental conditions that cause him depression, anxiety, mood instability, and sleep disturbances. Petitioner specifically alleged that his mental conditions include depression, generalized anxiety disorder, and PTSD. Depression, generalized anxiety disorder, and PTSD are medically determinable impairments that could reasonably be expected to cause Petitioner's alleged symptoms. Petitioner has sought medical treatments for his mental conditions. Petitioner's medical providers have diagnosed Petitioner with major depressive disorder, generalized anxiety disorder, and PTSD. Petitioner's medical providers have reported that Petitioner's marijuana use

is a contributing factor to his mental conditions. Although Petitioner testified that he has stopped using marijuana, Petitioner's medical records seem to indicate otherwise. Petitioner's medical providers have advised Petitioner to seek psychotherapy, but Petitioner has not sought psychotherapy yet. Petitioner's mental conditions are being treated with Cymbalta, hydroxyzine, and mirtazapine. Petitioner has reported that his mental conditions have improved with his medication, but Petitioner's medical providers continue to adjust Petitioner's medications as needed. Petitioner stated that he cannot do anything because he gets anxious. Petitioner's statement about the intensity and limiting effects of his mental conditions are inconsistent with the evidence presented.

Petitioner alleged HIV causes him low energy and vomiting. HIV is a medically determinable impairment that could reasonably be expected to cause Petitioner's alleged symptoms. Petitioner has tested positive for HIV, and Petitioner has sought medical treatment for HIV. Petitioner's medical providers have successfully controlled Petitioner's HIV with medication. Petitioner's HIV is currently treated with cabotegravir-rilpivirine. Petitioner reported suffering from side effects from this medication when he started it, but the side effects have settled. Petitioner stated that he has low energy and vomits multiple times per week. Petitioner's statement about the intensity and limiting effects of his HIV are inconsistent with the evidence presented.

Based on the evidence presented, Petitioner does not have any exertional or non-exertional limitations on his capacity to perform work. Although Petitioner has medically determinable impairments, Petitioner's impairments are controlled with medical treatment, and Petitioner did not present sufficient evidence to establish that his impairments limit his capacity to perform any work.

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 five 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 five years prior to his application consisted of work as a substitute teacher, a factory production worker, and a clerical office worker. Based on the RFC analysis above, Petitioner maintains the RFC to perform his past relevant work. Therefore, Petitioner is not disabled at Step 4, so the analysis ends at Step 4.

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.

IT IS ORDERED that the Department's determination is **AFFIRMED.**

JEFFREY KEMM
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:

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