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

Date Mailed: January 14, 2026
Docket No.: 25-038717
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

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

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

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.

Date Mailed: January 14, 2026
Docket No.: 25-038717
Case No.: [redacted]
Petitioner: [redacted]

HEARING DECISION

On October 31, 2025, Petitioner Nicole Scanna requested a hearing to dispute a State Disability Assistance (SDA) determination. As a result, a hearing was scheduled to be held on January 6, 2026. 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 and represented herself. Respondent Michigan Department of Health and Human Services (Department) had Eligibility Specialist Michelle Jauss appear as its representative. There were no other participants. Both parties provided sworn testimony, and one exhibit was admitted into evidence during the hearing. A 333-page packet of documents provided by the Department was admitted collectively as Exhibit A.

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 [redacted] 1988.
2. Petitioner lives with two roommates.
3. Petitioner's highest level of education is the 11th grade.
4. Petitioner has not obtained a GED.
5. Petitioner is proficient in the English language.
6. Petitioner is right-handed.
7. Petitioner is able to see with glasses to correct her vision.

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 uses marijuana daily. Petitioner takes four hits of marijuana each day before bed to help her sleep. Petitioner has been using marijuana for more than 20 years.

13. Petitioner is able to sit, stand, walk, reach, bend, and climb stairs.

14. Petitioner is able to walk approximately 200 steps before it becomes too uncomfortable to continue.

15. Petitioner walks 5-10 minutes daily on a treadmill.

16. Petitioner is able to lift objects weighing approximately 10 pounds.

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

18. Petitioner is able to dress, bathe, transfer positions, toilet, and eat on her own.

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

20. Petitioner spends most of her time at home watching television/videos and resting.

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

22. From March 2022 to May 2023, Petitioner was employed by a [redacted]. Petitioner was employed as a cook. Petitioner grilled and fried foods. Petitioner spent 100% of her time standing. Petitioner had to lift objects weighing up to 40 pounds once per month, and Petitioner had to lift objects weighing up to 10 pounds daily. Petitioner quit her job when her hours were reduced.

23. Petitioner has not tried to work since she quit her job at [redacted].

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

25. Petitioner completed a medical social questionnaire and submitted it to the Department. (Exhibit A, pp. 30-35). In the medical social questionnaire, Petitioner reported that the illnesses, injuries, and conditions that limit her ability to work are severe depression, anxiety, bilateral carpal tunnel, ADHD, and PTSD. Petitioner stated, "it's hard for me to sustain any meaningful activity. My depression and anxiety and PTSD are crippling to me every day."

26. Petitioner completed a functional report and submitted it to the Department. (Exhibit A, pp. 113-120). In the functional report, Petitioner reported that her illness, injuries, and conditions limit her ability to work by: "horrible depression every day, horrible anxiety every day, memory problems, inability to focus or concentrate on tasks, always tired, sleep problems, afraid of people, and tremors in hands." Petitioner reported that she takes the following medications: Fetzima 40 mg and 80 mg, Guanfacine ER 4 mg, Lithium ER 300 mg, and Quetiapine ER 200 mg. Petitioner reported that each of these medications makes her drowsy.

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

28. Petitioner's medical records reflected the following pertinent information:

    a. On [redacted] 2024, Petitioner met with Nurse Practitioner Lee Majeski at [redacted] for a follow-up visit following post left gastrocnemius recession. Petitioner reported improvement and did not have any unusual complaints. Petitioner reported that she was not experiencing pain, numbness, or tingling in the extremity. Petitioner complained of numbness and tingling lateral aspect of the contralateral thigh – mainly lateral distal. Nurse Practitioner Lee Majeski referred Petitioner to Dr. Thereseann Huprikar. (Exhibit A, pp. 322-323)

    b. On [redacted] 2024, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 1 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel IR 300 mg nightly for insomnia, Intuniv 3 mg nightly for emotional regulation, prazosin 2 mg nightly for nightmares, and gabapentin 900 mg nightly for RLS. Petitioner reported some days were better than others. Petitioner reported going to the gym seemed to help relieve her symptoms. Petitioner reported that she experienced brain fog some days, her anger was mostly controllable, and she was content with her depression level. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress

disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to increase her Intuniv to 4 mg nightly, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 288-296)

c. On [redacted] 2024, Petitioner met with Dr. Richard Howell at [redacted] for evaluation of bilateral hands. Petitioner complained of pain and shaking. Petitioner reported that her symptoms began gradually a few months ago. Petitioner reported that her pain was aggravated by activities. Petitioner reported unsuccessfully treating her pain with ibuprofen. Dr. Howell instructed Petitioner to follow up with Dr. Thereseann Huprikar for evaluation and treatment. (Exhibit A, pp. 317-318)

d. On [redacted] 2024, Petitioner met with Dr. Thereseann Huprikar at [redacted] for a follow-up visit for right lower extremity paresthesia. Petitioner reported numbness along her right lateral thigh to the knee as well as some swelling and redness in the right leg with some sensitivity to touch in the anterior leg. Dr. Huprikar performed an EMG/NCS of right lower extremity, and the test results were normal. (Exhibit A, pp. 319-321)

e. On [redacted] 2024, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 1 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel IR 300 mg nightly for insomnia, Intuniv 4 mg nightly for emotional regulation, prazosin 2 mg nightly for nightmares, and gabapentin 1,200 mg nightly for RLS. Petitioner reported that she was dealing with recently losing a friend to suicide. Petitioner reported experiencing restless legs, and Petitioner reported that she stopped taking gabapentin as it was not helping her legs. Petitioner reported that she was open to discontinuing Rexulti. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to discontinue her Rexulti, discontinue her gabapentin, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 278-287)

f. On [redacted] 2024, Petitioner met with Dr. Thereseann Huprikar at [redacted] for a hand tremor. Petitioner reported pain

interfering with sleep, getting dressed, quality of life, bathing, house/yard work, and exercise. Dr. Huprikar ordered a new EMG bilateral upper extremity. (Exhibit A, pp. 314-316)

g. On [redacted] 2024, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 1 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel IR 300 mg nightly for insomnia, Intuniv 4 mg nightly for emotional regulation, prazosin 2 mg nightly for nightmares, and gabapentin 1,200 mg nightly for RLS. Petitioner reported improvement after restarting Rexulti. Petitioner requested to continue with her medications without any changes. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to continue all medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 230-237)

h. On [redacted] 2024, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 1 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel IR 300 mg nightly for insomnia, Intuniv 4 mg nightly for emotional regulation, prazosin 2 mg nightly for nightmares, and gabapentin 900 mg nightly for RLS. Petitioner reported stress, irritability, anger, anxiety, and sleep disturbances. Petitioner requested to continue with her medications without any changes. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to continue all medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 217-225)

i. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 1 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel IR 300 mg nightly, Intuniv 4 mg nightly, and prazosin 2 mg

nightly for nightmares. Petitioner reported experiencing hallucinations the past one to two weeks. Petitioner also reported significant sleep disturbances. Petitioner reported that she had been diagnosed with sleep apnea, she had a CPAP, but she only used it one hour per night before removing it due to discomfort. Petitioner reported her depression had gotten worse over the past couple of weeks. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to increase her Rexulti to 2 mg nightly, discontinue her Seroquel IR for sleep, start Seroquel XR 200 mg nightly for insomnia and mood, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. Nurse Practitioner Eliza Sudbury prescribed mirtazapine 7.5 mg nightly for insomnia. (Exhibit A, pp. 208-216)

j. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 2 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel XR 200 mg nightly, Intuniv 4 mg nightly, prazosin 2 mg nightly for nightmares, and mirtazapine 7.5 mg nightly. Petitioner reported that her hallucinations have resolved since increasing Rexulti to 2 mg. Petitioner reported a poor mood, irritability, and anger. Petitioner reported sleeping better, but she reported that she struggles to stay asleep. Petitioner did not start Seroquel XR as previously instructed. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to decrease her lithium to restart Seroquel XR 200 mg nightly, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 199-207)

k. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 2 mg for mood, lithium ER 900 mg twice daily for chronic suicidal ideation and mood, Seroquel XR 200 mg nightly, Intuniv 4 mg nightly, prazosin 2 mg nightly for nightmares, and mirtazapine 7.5 mg nightly. Petitioner reported that adding Seroquel XR helped her fall asleep, but it did not keep her

asleep throughout the night. Petitioner reported feeling less irritable and anxious over the past month. Petitioner reported that she still had low energy, poor motivation, poor appetite, poor concentration, hopelessness, worthlessness, helplessness, restlessness, and anhedonia nearly every day. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to decrease her lithium to 900 mg every morning and 600 mg every evening, increase her Seroquel XR to 300 mg, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 188-196)

l. On [redacted] 2025, Petitioner met with Dr. Thereseann Huprikar at [redacted] for a follow-up visit for bilateral hand tremor and electrodiagnostic studies. Petitioner reported difficulty holding objects. Dr. Huprikar completed an EMG/NCS bilateral upper extremity. The test indicated right ulnar neuropathy at the elbow without Axon loss or conduction block and left ulnar neuropathy at the elbow without Axon loss or conduction block. (Exhibit A, pp. 311-313)

m. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 2 mg for mood, lithium ER 600 mg every morning and 900 mg every evening for suicidal ideation and mood, Seroquel XR 300 mg nightly, Intuniv 4 mg nightly, and mirtazapine 15 mg nightly for insomnia. Petitioner complained of sleepwalking, sleep-eating, and persistent irritability. Petitioner reported that she felt like she was sleeping a little more. Petitioner reported that she still had low energy, poor motivation, poor appetite, poor concentration, hopelessness, worthlessness, helplessness, restlessness, and anhedonia nearly every day. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to increase her Rexulti to 3 mg, decrease her Seroquel XR to 200 mg, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 179-187)

n. On [redacted] 2025, Petitioner met with Dr. Richard Howell at [redacted] for a follow-up visit for bilateral hand pain and

numbness/tingling. Petitioner reported continued pain. The record noted that Petitioner's EMG nerve conduction studies confirmed findings of bilateral cubital tunnel syndrome. Dr. Howell discussed Petitioner's options, including surgery. Petitioner chose to proceed with surgery on the left side first. (Exhibit A, pp. 308-310)

o. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 3 mg for mood, lithium ER 600 mg every morning and 900 mg every evening for suicidal ideation and mood, Seroquel XR 200 mg nightly, Intuniv 4 mg nightly, and mirtazapine 7.5 mg to 15 mg nightly for insomnia. Petitioner reported a recent sleep apnea diagnosis. Petitioner reported that she was going to start using a BiPAP machine for her sleep apnea. Petitioner reported that she falls asleep easily, but she wakes up in the night. The record noted that Petitioner's sleep problems are being addressed with a BiPAP machine, and Nurse Practitioner Eliza Sudbury will wait and see if it helps before making any other changes to Petitioner's treatment plan. Petitioner reported that she still had low energy, poor motivation, poor appetite, poor concentration, hopelessness, worthlessness, helplessness, restlessness, and anhedonia nearly every day. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to continue all medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 170-178)

p. On [redacted] 2025, Petitioner met with Physician's Assistant Lauren Bos at [redacted] for a post-operative visit following a left cubital tunnel release. Petitioner reported near complete resolution in per-operative symptoms and minimal post-operative pain. Physician's Assistant Lauren Bos removed Petitioner's sutures. The record noted that Petitioner could begin gentle range of motion exercises at the elbow, and Petitioner should maintain a 5-pound weight limit until she is 4 weeks from surgery. (Exhibit A, pp. 306-307)

q. On [redacted] 2025, Petitioner met with Nurse Practitioner Eliza Sudbury at [redacted] via videoconference for a medication review. The record indicates that Petitioner's medications consisted of Fetzima 120 mg daily for anxiety and depression, Rexulti 3 mg for mood, lithium ER 600 mg every morning and 900 mg every evening for suicidal ideation and mood, Seroquel XR 200 mg at bedtime and 50-100 mg

as needed in the middle of the night, Intuniv 4 mg nightly, and mirtazapine 15 mg nightly for insomnia. Petitioner reported that she recently started Zepbound for weight loss. Petitioner reported that she stopped using her sleep apnea machine after a few nights because it was ineffective. Petitioner reported that her mood was a little bit more open and a little bit freer. Petitioner reported that her medications have been helpful with her sleep. Petitioner reported that she still has low energy, poor motivation, poor appetite, poor concentration, hopelessness, worthlessness, helplessness, restlessness, and anhedonia nearly every day. The record indicates that Petitioner's suicidal ideation has been resolved. The record noted the following diagnoses: major depressive disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and disruptive mood dysregulation disorder. The record noted that Petitioner's depression, mood, anxiety, and social phobia were failing to improve as expected. Nurse Practitioner Eliza Sudbury instructed Petitioner to decrease her lithium ER to 600 mg twice daily, continue all other medications, continue psychotherapy, continue counseling, and follow up in four weeks. (Exhibit A, pp. 153-161)

29. The DDS determined that Petitioner did not have any exertional limitations on her ability to meet the physical demands of jobs. The DDS determined that Petitioner maintained the mental residual capacity to perform simple/routine tasks in a low-stress setting. (Exhibit A, pp. 41-51)

30. On October 16, 2025, the DDS determined that Petitioner was not disabled because she was capable of performing other work. (Exhibit A, p. 50)

31. On October 20, 2025, the Department issued a notice of case action to Petitioner to notify her that her application for state disability cash assistance was denied. (Exhibit A, pp. 11-16)

32. 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 depression, anxiety, bilateral carpal tunnel, ADHD, and PTSD. Based on the medical evidence presented in this case, the following listings were considered:

- 12.04 Depressive, bipolar and related disorders
- 12.06 Anxiety and obsessive-compulsive disorders
- 12.15 Trauma- and stressor-related disorders

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 depression, anxiety, bilateral carpal tunnel, ADHD, and PTSD. Accordingly, these are the impairments that will be analyzed.

The only exertional impairment that Petitioner alleged was bilateral carpal tunnel. Petitioner alleged that she has tremors in her hands and some discomfort after using her hands for more than a couple of hours. Petitioner has medical records that support her bilateral carpal tunnel diagnosis, and the medical records support Petitioner's assertion that she has discomfort in her hands. However, Petitioner recently had surgery on her left hand, and Petitioner's medical records show that Petitioner reported that she experienced nearly complete resolution of her pre-operative symptoms. Petitioner's statement about the intensity, persistence, and limiting effects of her symptoms is inconsistent with her medical records. Based on Petitioner's medical records, Petitioner may have some tingling or numbness in her left hand, and Petitioner may have some pain/discomfort in her right hand. However, Petitioner's bilateral carpal tunnel does not limit her capacity to perform work.

Petitioner alleged multiple non-exertional impairments. Petitioner alleged that she had depression, anxiety, ADHD, and PTSD. However, Petitioner asserted that the symptoms from these conditions were similar, and Petitioner asserted that her treatment was essentially the same for all these conditions. Petitioner has medical records that support her depression, anxiety, and PTSD diagnoses. Petitioner did not present sufficient medical records to support her ADHD diagnosis. Petitioner alleged that her conditions cause her problems with her mood, thoughts, sleeping, focusing, and communication. Petitioner stated that she experiences symptoms almost daily, and the symptoms last anywhere from less than one hour to the entire day. Petitioner alleged that her symptoms prevent her from doing anything productive. Petitioner's statement about the intensity and persistence of her symptoms is consistent with her medical records. However, Petitioner's statement about the limiting effects of her symptoms is inconsistent with her medical records. Based on Petitioner's medical records, Petitioner does not have any limitations on her ability to do anything productive.

Petitioner asserted that she has had the same non-exertional impairments for more than 20 years. Petitioner held a job at [redacted] for more than one year with her symptoms, and Petitioner did not present sufficient evidence to establish that her symptoms have changed since she held her job at [redacted]. Further, although Petitioner asserted that she could not follow instructions, remember, concentrate, or complete tasks, Petitioner's conduct during the administrative hearing showed that Petitioner is able to perform these basic mental functions for at least one hour. Petitioner was able to follow the hearing instructions. Petitioner was able to remember her past medical history, her hobbies, and her daily activities. Petitioner was able to focus on questions and respond with relevant information. Additionally, Petitioner's

medical records also show that Petitioner has been able to follow instructions, remember, concentrate, and complete tasks as Petitioner is able to effectively communicate with her medical providers and follow her medical providers' instructions.

Based on the evidence presented, Petitioner does not have any exertional limitations on her capacity to perform work. Petitioner has some non-exertional limitations on her capacity to perform work, but Petitioner maintains the mental capacity to perform simple and routine tasks. 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 her application consisted of work as a cook at a [redacted]. Petitioner's past relevant work was simple and routine. Based on the RFC analysis above, Petitioner maintains the RFC to perform her 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: **Respondent**
OTTAWA COUNTY DHHS
12185 JAMES ST STE 200
HOLLAND, MI 49424
MDHHS-OTTAWA-HEARINGS@MICHIGAN.GOV

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