

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

ALLEN C.,

Claimant,

vs.

SOUTH CENTRAL LOS ANGELES
REGIONAL CENTER,

Service Agency.

OAH No. 2010070064

DECISION

Administrative Law Judge Susan L. Formaker of the Office of Administrative Hearings heard this matter on March 29, 2011, in Los Angeles, California.

Allen C. (claimant) was represented by Educational Consultant Victoria Baca.¹ Claimant's parents, Araceli and Alejandro C., participated in the hearing and used the services of a certified Spanish-language interpreter.

Johanna Arias-Bhatia, Fair Hearing Manager, represented South Central Los Angeles Regional Center (SCLARC or Service Agency).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on March 29, 2011.

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¹ Claimant and his relatives are identified by first names and last initials to protect their privacy.

ISSUE

Whether claimant is eligible to receive services from Service Agency under the Lanterman Developmental Disabilities Services Act (Lanterman Act), Welfare and Institutions Code section 4500 et seq.

FACTUAL FINDINGS

I. Parties and Jurisdiction

1. Claimant was born on June 10, 2004. He lives at home with his parents and siblings. His dominant language is Spanish.

2. On May 26, 2010, Service Agency notified claimant's mother of its determination that claimant is not eligible for regional center services because he does not meet the eligibility criteria set forth in the Lanterman Act.

3. Claimant's father filed a timely fair hearing request to appeal Service Agency's determination regarding eligibility. Claimant's parents contend he is eligible to receive regional center services because he has autism.

4. Claimant's parents rely primarily on evaluations performed by his school district and Kaiser Permanente to support their claim that claimant suffers from autism.

II. Claimant's School Evaluations and School Services

5a. In October of 2009, claimant was referred for a psychoeducational evaluation to be conducted by the Downey Unified School District (DUSD) because of concerns about his non-compliant behavior, his speech and language delays, his academic progress, and the appropriateness of his school placement. He had a history of aggressive behavior. At the time, claimant's mother reported her primary concern as being his inability to concentrate. He would not listen or sit still, and he had severe temper tantrums. Claimant's mother also reported that he would imitate behaviors he saw and repeat what he heard, that he listened to the same songs repeatedly, that he would repeat certain phrases to a bothersome degree, and that he was timid both with strangers and some relatives. She additionally reported that claimant had met his developmental milestones, including for speech, within the average age of development (although he continued to wear diapers for some time). Claimant was reportedly able to say distinct words by one year of age and to use phrases of at least three to four words by the age of four. Claimant's mother reported that he did not pass a hearing and vision assessment because he was not able to follow the directions.

5b. Teresa Guerrero, the school psychologist at claimant's elementary school, prepared the psychological report regarding claimant for the DUSD. During the psychoeducational evaluation, claimant was not timid with Ms. Guerrero. However, she observed that he had extreme difficulty staying on task, was very talkative about things in

which he was interested, and repeated everything that was said to him. He became highly noncompliant when he tired of a task. He was very impulsive, spoke without listening to what was being said to him, and touched test stimuli throughout the testing. Claimant had difficulties with speech and language. He engaged in imaginative play, could complete simple puzzles, and could name his body parts, animals, and some colors. However, he had difficulty associating sounds with letters and with some fine motor skills (such as holding a pencil and reproducing shapes). During class, he was very disruptive, sought the attention of his teacher, and was in constant motion. Claimant sometimes stared blankly as if daydreaming, but he also attempted to seek the company of others (usually to chase or disturb them). He invaded the personal space of other students and appeared to be obsessed with playing with or pulling the hair of other children.

5c. As part of the DUSD psychoeducational evaluation, claimant's teacher completed the Connors Rating Scale, a diagnostic rating scale based on observed behaviors that can indicate the presence of behaviors consistent with Attention Deficit Hyperactivity Disorder (ADHD). Claimant scored in the "significant" range. Claimant's teacher and the school psychologist performing the psychoeducational evaluation both also completed the Childhood Autism Rating Scale (C.A.R.S.), a diagnostic rating scale based on observed behaviors that can indicate the presence of behaviors consistent with autism. Claimant's overall reported behaviors fell within the "mild to moderate" range of autism. Claimant's teacher additionally completed the Behavior Assessment System for Children, Second Edition (BASC-2), a scale used to help assess the presence of problematic behaviors in children. Claimant scored within the clinically significant range in the areas of attention and attentional problems, aggression, withdrawal, adaptability, social skills, and communications.

5d. Claimant demonstrated an ability to solve problems and use logic during cognitive testing. Nonetheless, because of claimant's noncompliant and impulsive behavior during the DUSD psychoeducational assessment, the cognitive testing results were viewed with caution. Claimant's cognitive abilities were estimated to be in the low average range, with his academic skills (based on the Wechsler Individual Achievement Test, Second Edition) estimated to fall within the pre-kindergarten range. The estimate of his adaptive skills was in the average range overall, with deficits in the areas of socialization and communication. Claimant also scored in the very low range on the VMI Test of Visual-Motor Integration. Auditory processing testing could not be assessed due to claimant's impulsive and uncooperative behavior, but Ms. Guerrero noted in her evaluation that claimant has a "keen memory" and "is capable of repeating exactly what is said to him" without "appear[ing] to process the fact that the examiner was asking him a question." (Exhibit 9.) Ms. Guerrero concluded that claimant "does exhibit characteristics that are consistent with autistic-like behaviors," but she did not provide a diagnosis. (*Ibid.*)

5e. As part of the DUSD psychoeducational evaluation, a speech and language evaluation was performed by Joan M. Cafferty, a speech and language pathologist. Ms. Cafferty noted in her report that claimant was generally cooperative during the testing, but his attention frequently needed to be brought back to the task. Claimant was much more communicative when given things he could manipulate than when he was asked to point to

pictures, and he sometimes spontaneously demonstrated the ability to use or understand language in ways the testing did not show. He used eye contact, but not as much as Ms. Cafferty believed would be expected. Claimant demonstrated significant difficulties with semantics, syntax-morphology, articulation/phonology, and language pragmatics. While claimant demonstrated stronger expressive language skills than receptive language skills, both his expressive and receptive language skills were delayed. He had difficulty understanding and using language to communicate effectively. His ability to use “joint attention,” that is, to engage with the same thing as Ms. Cafferty during the evaluation, was inconsistent.

5f. During the time the DUSD was performing its psychoeducational evaluation, Kaiser Permanente (Kaiser) performed an evaluation of claimant at his parents’ request. According to the DUSD evaluation, the DUSD was notified by a letter from Kaiser on October 30, 2009, that claimant had been diagnosed as autistic. A letter (Exhibit 20) dated October 30, 2009, from Dorothy K. Yungman, LCSW, of Kaiser was admitted in evidence at the hearing and presumably was the letter provided to the DUSD; it stated that Ms. Yungman had evaluated claimant and diagnosed him with autism. There were no test results or reports showing how Ms. Yungman had arrived at such a diagnosis.

6. Following the DUSD psychoeducational evaluation, an Individualized Education Program (IEP) was created for claimant, and he was placed in a special day class for kindergarten, with additional speech and language services twice per week. The primary disabling condition was identified as “Other Health Impairment,” with “Speech/Lang[uage] Impairment” being identified as the secondary disabling condition. (Exhibit 13.) The IEP mentioned claimant’s “autistic-like behaviors” as a possible basis for eligibility for special education services.

7a. After the initial IEP meeting on November 5, 2009, claimant’s parents sought review by the DUSD of the primary disabling condition entitling claimant to special education services. DUSD’s District Psychologist, Graceann Frederick, M.S., obtained claimant’s birth records, spoke with Ms. Yungman (referred to in Finding 5f), and observed claimant in his classroom. She also administered the Vineland Adaptive Behavior Scales, Second Edition (VABS) - Teacher Rating Form, a diagnostic aid measuring personal and social skills, as actually performed, that are needed for everyday living in the school setting. In early December, 2009, Ms. Frederick prepared an addendum to the DUSD psychoeducational report, which is summarized below.

7b. Claimant’s mother reported that his umbilical cord was wrapped around his neck at birth. His birth records stated that his Apgar scores (consisting of five criteria to assess newborn health immediately after birth) were good, with the only initial area of concern being his color. His color scores suggested he had a blue or pale color at one minute and a pink body color with blue extremities at five minutes. Nevertheless, claimant apparently was discharged from the hospital in good health and there was no indication that his color at birth was associated with any behavioral, language, or cognitive problems.

7c. During Ms. Frederick's classroom observation of claimant, he engaged in many of the same types of inattentive, uncooperative, disruptive, and obsessive behaviors described in the original DUSD psychoeducational evaluation. He constantly touched and smelled other children's hair (even placing another child's hair in his mouth), moved around the class, manipulated and tapped objects in a non-functional manner, played with water, engaged in indirect eye contact (glancing back from a distance), and spoke to himself, sometimes in jargon. Claimant exhibited self-stimulatory behaviors, such as repeating actions and words frequently. He could use materials appropriately only when in a structured one-to-one setting with an adult. His social interactions with peers were generally atypical.

7d. Based on claimant's teacher's completion of the VABS - Teacher Rating Form, Ms. Frederick found claimant's overall adaptive behaviors in the school setting to be significantly below the average range. Socialization was the domain of greatest relative weakness for claimant; his motor skills, which fell within the moderately low range, were his greatest relative strength.

7e. Ms. Frederick recorded in her addendum to the psychoeducational report that Ms. Yungman confirmed she had diagnosed claimant with autism but that he would be further evaluated by a Kaiser developmental pediatrician. The addendum indicated that Ms. Yungman's diagnosis was based on claimant's parents' reports and her observation.

7f. Ms. Frederick concluded that claimant demonstrated "autistic-like behaviors," that his self-stimulatory, narrow interest, and repetitive behaviors interfered with his ability to access the general education curriculum, and that his communication and socialization skills were delayed. She recommended that "autistic-like behaviors" should be considered as claimant's primary disabling condition as the basis for his eligibility for special education services.

8. Another classroom observation was performed by Billie Barrios on behalf of the DUSD on December 9, 2009. Ms. Barrios observed claimant engaging in many of the same types of behaviors that had previously been observed (set forth in Findings 5b and 7c above). However, in Ms. Barrios's report of her observations, she indicates that claimant initiated verbal communication with a teacher when he received one-on-one attention and smiled when the teacher provided positive reinforcement for staying on task. He also waved at Ms. Barrios and initiated communication with, and smiled at, another student. Thus, while he was often disruptive, uncooperative, and apparently ignored many social cues, he did sometimes engage in socially appropriate behavior.

9. In an IEP addendum agreed to on February 4, 2010, the basis for claimant's eligibility for special education services was changed to "autism," with "autistic-like behaviors." The IEP addendum noted that claimant was being successful in school with the additional structure and supports and the high adult-to-student ratio available in the special education classroom. Neither the definition of "autism" under the Lanterman Act nor the diagnostic criteria for "Autistic Disorder" under the American Psychiatric Association's

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (2000) (DSM-IV-TR) (discussed at Finding 14 below) were analyzed in making claimant eligible for special education services under an eligibility category of “autism.”

10. Claimant continues to receive special education services from the DUSD. Claimant’s most recent Individualized Education Program (IEP) introduced into evidence, dated November 1, 2010 (Exhibit C), identifies “autism” as the primary disabling condition entitling him to special education services. Claimant is placed in a special day class and additionally receives one hour per week of speech and language services at his school.

11. Claimant’s November 1, 2010 IEP reflects that he is doing much better in school with the special education services he receives. He exceeded a number of his goals, although he is still not performing at grade level. He has “lots of friends,” “pals with other kids at recess,” “is well liked by all his peers,” and “does not get into trouble at recess time.” (Exhibit C, at pp. 2 and 6) Although he sometimes gets too close to other students and puts his hands on them to hug them, he does not hurt others and is reminded to keep his hands to himself. Claimant is able to sit for 15-30 minutes at a time with non-preferred activities, can work with a partner, and typically works in small groups in his class. While he still gets off task, he is able to get back on task with simple reminders. He completes all his class work and homework. He is able to take care of all his needs at school independently. His language skills “have improved tremendously,” and he “asks questions and is constantly interacting with other students.” (*Ibid.*) Pursuant to the November 1, 2010 IEP, claimant’s parents and school agreed he would be mainstreamed 30 minutes four times per week for English Language Development services, with the special education and speech and language services continuing. He has no behavioral goals and does not require behavioral intervention at school.

III. Kaiser Evaluation of Claimant

12a. A Multi Disciplinary Developmental Team Report revised as of July 30, 2010 (Kaiser report), was prepared by Dr. Marvin Tan, Developmental Pediatrician, and other health professionals, at Kaiser.

12b. The Kaiser report recounts claimant’s parents’ reports of his development and behavior, which expanded on, and differed somewhat from, their prior reports and claimant’s November 1, 2010 IEP. According to the Kaiser report, in addition to claimant’s history of being unusually shy, his parents stated that his speech began to regress when he was approximately three years of age. His speech regression took the form of dropping words from phrases and giving off-topic answers to questions. The Kaiser report states claimant continues to have language delays, including not using personal pronouns, engaging in echolalia, failing to maintain the topic in conversations, and having perseverative speech patterns (such as repeating statements about his interests). The Kaiser report details Claimant’s poor eye contact, his getting too close to other children and touching them or grabbing their hair, and his persistence in his behavior even after other children protest. Claimant’s parents reported he is unable to play or interact for more than five minutes

because of his behavior. They said he could point out interesting things to his them, but had difficulty taking turns with children, engaging in reciprocal play, or perceiving how his behavior affects others. Claimant's parents reported claimant's need for attention from his family, his insistence on getting his way, and his severe, frequent tantrums and aggressive behavior. They also identified claimant's rigid, ritualized, or atypical behaviors, such as coloring only in blue, listening to the same two or three songs for hours, wearing the same clothes each day, arranging items in a certain order, repetitively turning lights on and off, getting upset with changes in routine, and flapping his hands when he is upset or excited. The Kaiser report notes that claimant sometimes wets and soils himself. Some of claimant's parents' reports of his communications were somewhat inconsistent with their generalized reports to the Kaiser multidisciplinary team. In a response to a pragmatic skills checklist, they reported claimant often makes polite requests or statements, sometimes greets, excuses and thanks appropriately, sometimes engages in conversation relevant to time and place, usually uses or interprets facial expressions and gestures appropriately, and sometimes maintains appropriate eye contact. However, they noted claimant rarely takes conversational turns, gets the attention of a listener appropriately or understands what is being said to him, never adjusts conversation to peers or adults, never enters a group appropriately or makes appropriate statements, and never reacts appropriately to humor. (Exhibit A, at p. 9.)

12c. The Kaiser multidisciplinary team administered the modified Gesell Schedule to assess claimant's development, using observations of claimant's behaviors and reports from claimant's parents. In their observations, claimant was able to attend to tasks for approximately one minute and, with redirection, was able to complete them. However, he intentionally bumped into chairs and people. Claimant was able to tolerate changes to tasks with cues. He sometimes ignored the therapist. Claimant's scores on the modified Gesell Schedule indicated claimant demonstrates delays in his fine and gross motor skills. The Kaiser report identifies limited motor planning and ideation as contributing factors to delays in his daily living, play, and motor skills. It also indicates that claimant's poor processing of somatosensory input impacts his performance and ability to engage in motor sequences required for age appropriate skills; his language delays affect his ability to participate in his environment.

12d. According to the Kaiser multidisciplinary team, Claimant has severe deficits in both receptive and expressive language skills, and his play skills and language pragmatics are also significantly delayed. For example, his language pragmatics, as measured using the Pragmatic Judgment subtest of the Comprehensive Assessment of Spoken Language (CASL), reflected a score in the first percentile. The Kaiser multidisciplinary team confirmed that Claimant exhibited some echolalia and used "you" in place of "I." On the other hand, Claimant's eye gaze did not appear to be consistently assessed through various measures. For example, at one point in the Kaiser report, Claimant's eye gaze was found to be only "mildly reduced." (Exhibit A, at p. 8.) Claimant would look at an adult on request, sit down on request, and demonstrate communicative intent, including showing, pointing and verbalizing. His turn-taking was inconsistent, as he would not engage in more than one verbal exchange. Later in the report, Claimant was observed to have "poor eye contact" during an unstructured portion of the evaluation. (*Id.*, at p. 10.) Claimant became engrossed

in playing with a handheld game and Legos, and flapped a Lego based in a repetitive fashion. He ignored his brother and generally would not engage in social toy play or other interaction with the examiner during the unstructured portion of the evaluation. He also spontaneously spoke in short sentences that were out of context.

12e. The Kaiser report notes that the multidisciplinary team administered the Pervasive Development Disorder Screening Test (P.D.D.S.T.). Claimant received a score of 4, when a score of 9 or more indicates a need for further evaluation to rule out autism. The Kaiser multidisciplinary team administered the C.A.R.S. assessment instrument (which had previously been administered by the DUSD, as set forth in Finding 5c). The Kaiser report notes that claimant scored 39, and that a score of 30 or more is consistent with autism. They also administered the Gilliam Autism Rating Scale - Second Edition (GARS-2) assessment instrument. Claimant was assessed with an Autism Index score of 83. The Kaiser report notes that a score of 85 or higher indicates that the subject is likely to have autism, and that a score of 70 to 84 indicates that the subject may have autism. On the VABS, the Kaiser multidisciplinary team assessed claimant with an adaptive behavior composite score of 73 (delayed). His scores in the socialization area were in the markedly delayed range (with a standardized score of 63); his scores in the other areas (communication, daily living skills, and motor skills) were in the delayed range (with standardized scores of 79, 83, and 81, respectively). The Kaiser report notes that claimant shows “marked variability” in his adaptive skills, with socialization and oral language skills “at or below the 2 year 10 month level” and his written language skills being an area of relative strength. The report notes that “[t]his pattern of relative strengths and weakness is common in children with autism.” (Exhibit A, at p. 12.)

13. Based on claimant’s history and patterns of behavior, the Kaiser multidisciplinary team found that claimant “fits the pattern for a diagnosis of autism.” The Kaiser report sets forth an Axis I diagnosis of Autistic Disorder, as well as Enuresis and Encopresis, under the DSM-IV-TR.² The Kaiser report deferred a diagnosis on Axis II, and diagnosed Motor Delays on Axis III.

14. Under the DSM-IV-TR, the criteria for Autistic Disorder are identified as follows:

² The Administrative Law Judge takes official notice of the DSM-IV-TR as a highly respected and generally accepted tool used by practitioners in diagnosing mental and developmental disorders. DSM-IV-TR allows for a total of five axes to be utilized to describe different aspects of a disorder or disability. Axis I refers to clinical disorders (including major mental disorders, developmental and learning disorders, and substance abuse disorders), Axis II refers to personality disorders and intellectual disabilities, Axis III refers to acute medical conditions and physical disorders, Axis IV refers to psychosocial and environmental factors contributing to a disorder, and Axis V is a Global Assessment of Functioning or Children’s Global Assessment Scale score.

“A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

- (1) qualitative impairment in social interaction, as manifested by at least two of the following:
 - (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - (b) failure to develop peer relationships appropriate to developmental level
 - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - (d) lack of social or emotional reciprocity

- (2) qualitative impairments in communication as manifested by at least one of the following:
 - (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - (c) stereotyped and repetitive use of language or idiosyncratic language
 - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

- (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
 - (c) stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - (d) persistent preoccupation with parts of objects

“B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

“C. The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.” (Exhibit D, at p. 70-71.)

15. The DSM-IV-TR section on Autistic Disorder notes that “[i]n a minority of cases, parents report regression in language development, generally manifest as the cessation of speech after a child has acquired from 5 to 10 words.” (Exhibit D, at p. 67.) It further notes that “[b]y definition, the onset of Autistic Disorder is prior to age 3 years”; moreover, “[i]n Autistic Disorder, developmental abnormalities are usually noted within the first year of life.” (*Id.*, at p. 69.)

16. To diagnose claimant with Autistic Disorder, the Kaiser multidisciplinary team apparently applied the DSM-IV-TR criteria to claimant’s behaviors as follows:

“Based on history and current patterns of behavior, [claimant] fits the pattern for a diagnosis of autism. In the area of social interaction, he has shown poor eye contact throughout his life and touches others inappropriately (1a) and has never been able to play with others or make friends, despite social interest (1b). He has difficulty taking turns, taking different roles in a game and he has tantrums and becomes aggressive if his demands are not met immediately. He has reduced awareness of emotions and difficulty grasping the effect of his behavior on others (1d). Allen’s language skills are severely delayed with regression and atypical pronoun usage (2a). He has difficulty sticking to the topic of a conversation as well as many other aspects of pragmatic language (2b). Echolalia and perseverative speech are present (2c). Pretend play emerged late and is limited and repetitive (3d). Preoccupations emerged when Allen was a toddler and have included Spiderman and Star Wars, coloring, and listening to specific music (3a). He insists on certain routines and ordering of things at home and at school and becomes unusually upset when his expectations are not met (3b). Repetitive behaviors include jumping, flapping his hands (3c), touching hair, opening/closing doors and windows, etc. (3d).” (Exhibit A, at p. 12.)

17. The Kaiser multidisciplinary team recommended, among other things, claimant’s referral to Service Agency for a determination of eligibility and case management services.

18. No one who participated in the preparation of the Kaiser report or the Kaiser multidisciplinary team testified during the hearing of this matter. There was no evidence as to how the Kaiser multidisciplinary team differentiated between a diagnosis of autism and other possible diagnoses, except as set forth at Finding 16. The Kaiser report fails to discuss the fact that claimant’s parents reported he had normal language development up to the age of three (in contrast to the language in the DSM-IV-TR set forth at Finding 15) or the fact that the only unusual characteristic apparently displayed by claimant before the age of three was shyness (which exists in children who do not suffer from Autistic Disorder). There is no discussion as to the inconsistencies in the various test measures for autism. The Kaiser report also appears to have overstated the presence of a number of the behaviors that underlie the criteria for Autistic Disorder, such as when it equates claimant’s “reduced awareness of emotions and difficulty grasping the effect of his behavior on others” as a “lack of social or

emotional reciprocity” under criteria 1(d). Accordingly, the conclusions in the Kaiser report are questionable.

IV. Service Agency’s Assessment of Claimant

19. At the same time claimant was being assessed by Kaiser and by the DUSD, Service Agency was in the process of assessing claimant for eligibility for regional center services. Claimant was referred to Service Agency based on a letter from Marvin Lloyd Tan, M.D., of Kaiser dated December 18, 2009. That letter reported that claimant had been diagnosed with “Autism Spectrum Disorder based on his deficits in social skills, language and the presence of atypical behaviors.” (Exhibit 19.) Dr. Tan noted that he also believed claimant has “significant disabilities in the areas of self-direction, language and learning as a result of this disorder.” (*Ibid.*)³

20. On December 21, 2009, Maritza Cortés, Intake Service Coordinator for Service Agency, documented a social assessment of claimant, based on reports by claimant’s parents and her observations of claimant. Claimant willingly came to the interview room. He did not establish eye contact upon being greeted, and he failed to use appropriate eye contact to initiate and regulate social interaction. He displayed echolalia, and he spun around the office. Claimant was active and looked for toys. He needed prompting from his parents to participate in the assessment. Many of the behaviors reported by claimant’s parents regarding his behavior were similar to those reported during other assessments. However, during the social assessment with Service Agency, claimant’s parents reported that he spoke in two- to three-word phrases by the age of 12 months, with his speech regressing to one-word utterances at the age of 30 months, thus suggesting an earlier (and somewhat different) speech regression than was reported to Kaiser. They also reported that claimant exhibited self-injurious behaviors, including hitting his head with his hand and hitting himself with a fork or pencil--behaviors not reported earlier. Ms. Cortés recommended a psychological examination and determination as to claimant’s eligibility for regional center services.

21a. On February 9, 2010, Ann L. Walker, Ph.D., performed a psychological evaluation of claimant. Dr. Walker is a licensed clinical psychologist who has consulted for the Service Agency since 1986, primarily conducting evaluations to help determine eligibility for SCLARC’s services. She reviewed the social assessment performed by Ms. Cortés, the DUSD reports and records through mid-December summarized above, and Dr. Tan’s letter of December 18, 2009. She also administered various assessment tools to determine whether claimant has autism. Dr. Walker did not participate in the decision as to whether claimant is eligible for regional center services; she provided her report (Exhibit 5) to Service Agency to make that determination.

³ It is unclear whether the diagnosis of “Autism Spectrum Disorder” was different in the view of the Kaiser multidisciplinary team from its diagnosis of Autistic Disorder. There is no disorder under the DSM-IV-TR known as “Autism Spectrum Disorder.”

21b. Dr. Walker found that claimant had an attention span of only approximately one minute and that he was constantly moving. He showed fleeting eye contact with her, and occasionally he displayed echolalia. When Dr. Walker tried to interview his parents, claimant became disruptive and seemed to do whatever he could to become the center of attention, eventually having a tantrum.

21c. Dr. Walker administered the Wechsler Preschool and Primary Scale of Intelligence - III (WPPSI-III); his verbal score was 75 (in the borderline range) and his performance score was 93 (in the normal range), with an overall score of 81 (a borderline score). Because of claimant's activity level and brief attention span, Dr. Walker felt that the cognitive testing likely provided an underestimate of claimant's true abilities.

21d. On the VABS, claimant's communication skills, daily living skills, socialization skills, and motor skills were all in the borderline range (with standardized scores of 72, 79, 73, and 81, respectively). Dr. Walker assessed claimant's adaptive behavior composite score at 73 (the same score assigned in the Kaiser report). With respect to social skills, Dr. Walker noted that claimant sometimes shares toys, could sometimes play with other children for up to five minutes, and would initiate interaction with other children and seek them out to play; however, after two to five minutes, he would begin to argue and fight with other children.

21e. Dr. Walker also administered the Autism Diagnostic Observation Schedule (ADOS), Module 2, which is used to assess behavioral affective functioning through standardized tasks which yield a series of scores. She assessed claimant as being in the non-autistic range, with a total score of six (and with scores of three each in the areas of communication and reciprocal social interaction); a score of 12 or above indicates the presence of autism. Claimant could not engage in conversation, but he spoke a lot during the evaluation. He engaged in imaginative play with a doll, pretending the doll was having a birthday party (and stating that the doll was claimant). He also engaged in brief reciprocal social interaction with Dr. Walker and initiated joint attention by taking turns in blowing bubbles. His social overtures towards Dr. Walker were "appropriate and friendly," and his social response was also "appropriate." (Exhibit 5, at p. 4.) However, once Dr. Walker sought to interview claimant's parents, he began to become disruptive and to tantrum.

21f. On the Autism Diagnostic Interview - Revised (ADI-R), which utilized an interview with claimant's parents, Dr. Walker assessed claimant as being in the non-autistic range in the reciprocal social interaction and communication skills subtests. Claimant's parents confirmed that claimant cannot engage in reciprocal conversation (sometimes insisting on specific responses to questions he asks), but he initiates interaction with other children and can engage in imaginary play. They told Dr. Walker that claimant's play dissolves into arguments with other children because claimant cannot understand what other children say to him, they cannot understand claimant, and claimant becomes aggressive. They also told Dr. Walker that claimant shows emotional reciprocity, noticing what others feel and trying to comfort them, although he can be inconsiderate of others' feelings. The only subtest within the autism range was with respect to restricted and stereotypic patterns of

interest. Claimant's parents reported that claimant was only interested in one Star Wars action figure and only a few songs. They did not report repetitive motor mannerisms to Dr. Walker.

21g. Dr. Walker assessed claimant as being in the non-autistic (unlikely) range on the GARS-2, with a score of 64, although all of his subtest scores (in stereotypic behavior, communication skills, and social interaction skills) were in the range of a possible probability of autism (with standardized scores of 4, 5, and 4, respectively). Dr. Walker noted that claimant's parents reported he could have temper tantrums 15 to 20 times per day on some days.

21h. Based on her testing of Claimant, Dr. Walker's DSM-IV-TR diagnostic impressions of claimant were of Attention Deficit-Hyperactivity Disorder, Combined Type, Oppositional Defiant Disorder, Disruptive Behavior Disorder NOS (very frequent temper tantrums), and Mixed Receptive Expressive Language Disorder (by history) on Axis I. She further assessed claimant with a Children's Global Assessment Scale score of 50.

21i. Dr. Walker concluded in her report:

“[Claimant] does not meet diagnostic criteria for the diagnosis of Autistic Disorder. He shows many behaviors inconsistent with the diagnosis of Autistic Disorder. [Claimant's] parents report that he sometimes can use eye contact to modulate social interaction. [Claimant's] parents report that he is developing peer relationships appropriate to his developmental level in that he initiates interaction with other children and will go to play with children who approach him. He was observed engaging in cooperative, interactive, imitative, and imaginary play. [Claimant] is able to share interest and enjoyment. He shows emotional reciprocity. [Claimant] shows no repetitive motor mannerisms and no preoccupation with parts of objects. For all these reasons, the diagnosis of Autistic Disorder is not recommended.” (Exhibit 5, at p. 6.)

Dr. Walker testified that this discussion reflected her consideration of the diagnostic criteria for Autistic Disorder. (See criteria set forth in Finding 14.)

21j. Dr. Walker noted that to make a consumer eligible for SCLARC's services, a diagnosis of autism must satisfy the diagnostic criteria of the DSM-IV-TR. Dr. Walker testified that, administered together, the ADOS and ADI-R tools are the “gold standard” for diagnosing Autistic Disorder as defined in the DSM-IV-TR, and that the GARS-2 provides additional information to provide a complete evaluation. She received training in the administration of these tests, which use standardized scores based on the behaviors observed or reported. Dr. Walker noted that although claimant exhibits significant behavioral concerns, including his short attention span, his oppositional, defiant, and hard to manage behavior, and his constant temper tantrums, he did not meet the criteria for autism. On direct examination, Dr. Walker testified that no delays in reciprocal interactive skills were reported or observed and that claimant's peer relationships were appropriate for his developmental level. This aspect of her testimony appeared to understate the atypicalities in claimant's communication and social skills.

21k. On cross-examination, Dr. Walker acknowledged that there were abnormalities in claimant's communication, including his inability to engage in reciprocal conversation, his echolalia or jargoning, and his inappropriate responses. She also acknowledged that while it is unusual, it is possible to have dual diagnoses of Autistic Disorder and ADHD. However, she noted that children with Autistic Disorder are "in their own world[s]" and, contrary to claimant, do not seek to have attention directed towards them. Dr. Walker found that claimant could convey his thoughts, use non-verbal means (such as pointing) to engage other people, initiate social overtures, use facial expressions to communicate feelings, and spontaneously seek joint attention. She additionally determined that he could present appropriate social responses and be playful and friendly, all behaviors inconsistent with Autistic Disorder, according to Dr. Walker. Claimant's impulsivity, constant non-repetitive movement, lack of focus, and brief attention span are characteristics of ADHD, not Autistic Disorder, according to Dr. Walker.

21l. Dr. Walker further acknowledged on cross-examination that the DSM-IV-TR criteria for a diagnosis of Disruptive Behavior Disorder NOS require that behavior cannot meet the criteria for Oppositional Defiant Disorder, despite the fact that she diagnosed claimant with both disorders. She testified that she added Disruptive Behavior Disorder NOS to her diagnosis to illustrate the extreme nature of claimant's temper tantrums. This contention was of some concern, given Dr. Walker's failure to note in her report that she was listing a diagnosis of Disruptive Behavior Disorder NOS for descriptive purposes only.

22. After receiving Dr. Walker's report, SCLARC's Comprehensive Autism Screening Team (CAST) carried out a second evaluation of claimant to determine whether he was eligible for regional center services based on a diagnosis of autism. The CAST team consisted of a psychologist, an education specialist, an occupational therapist and a speech-language pathologist. In addition to reviewing Dr. Walker's report and the DUSD and Kaiser documents reviewed by her, the CAST team reviewed an occupational therapy assessment prepared by Kaiser, which was not submitted in evidence. Members of the CAST team performed observations of claimant's play interactions with his parents and various team members, interviewed claimant's parents, and observed claimant in his classroom.

23a. As set forth in the CAST Observation report (Exhibit 6), claimant was observed to share his interests with others, to demonstrate intentional two-way communications, to demonstrate sustained attention to tasks, and to demonstrate interest in various toys, although his play skills were delayed. Claimant's teachers reported that claimant sometimes sought out interactions with peers. It was also reported that claimant understood others' facial expressions, feelings, and related consequences, such as when he saw a frown on a teacher's face and asked if the teacher was mad at him. In the classroom, claimant followed a morning routine and instructions without difficulty, and he exhibited appropriate classroom behavior. His teacher reported he transitioned well into small group centers, his math skills were at grade level, and he interacted with his peers (although he occasionally hit them). Claimant's teacher considered him to be easily re-directable and one of two of the top students in his class. On the other hand, some of the concerns observed or

reported were his poor sleeping habits, his below-average language skills, and his delayed play development (including needing prompting to engage in symbolic play, a failure to sequence related play actions, and lining up blocks and figurines). Although claimant's parents said he understood the feelings of others, he had difficulty translating what he knew to appropriate actions. His teacher stated he had poor impulse control, and his parents reported poor safety awareness. According to the CAST report, Kaiser's occupational therapy assessment indicated claimant has poor motor planning skills and problems with processing proprioceptive, auditory, and tactile sensory information.

23b. In its report, the CAST team noted that:

“[Claimant] . . . presented with delayed language and play skills and with behaviors and test results that represent concomitant sensory processing and regulatory disorders. [Claimant's] play skills are delayed with simple symbolic play that lacked the initiation of new ideas and sequencing of related play actions.” (Exhibit 6, at p. 3.)

The CAST team suggested that claimant's sensory processing and integration issues could be associated with his delays in motor planning and play development, and that his poor sleeping habits could be associated with his attention, impulsivity, motor planning, and safety awareness problems. The team went on to note:

“During the team observation, [claimant] demonstrated minimal difficulties in relating and interacting with the clinical specialists and his parents. It was reported by both parents and teacher that he understands facial expressions of others but may not respond appropriately through his actions; he reportedly has some impulse control difficulties (e.g., hitting others, pulling hair, not inhibiting inappropriate actions when told to) but at school, is reported to be easily redirected. This is what makes the diagnosis of autism questionable. Instead, the team considers the diagnostic category, Disorder of Infancy, Childhood and Adolescence - NOS (313.9), to be a more appropriate description for the behaviors he presents.” (Exhibit 6, at pp. 3-4.)

24. Monique Craig-Douglas, M.S., the education specialist on the CAST team, testified during the hearing. She confirmed that during her observations of claimant, she did not see the behaviors typically consistent with autism, such as ritualistic behaviors; instead, she observed distractibility and impulsive behavior, where claimant would not stay focused on a task, would get up and move around, and then would need redirection. Ms. Craig-Douglas did not observe any echolalia, hand flapping, or spinning.

25. Dr. Sandra Watson, Psy.D., the psychologist from the CAST team, also testified during the hearing. As a staff psychologist with SCLARC, Dr. Watson was additionally part of the core staffing team that made the determination as to claimant's lack of eligibility for regional center services. The core staffing team was made up of Dr. Watson, a physician, another psychologist, the intake coordinator, and the service coordinator responsible for claimant's case. Before denying claimant's request to become a regional center client, the core staffing team reviewed the available prior reports, although Dr. Watson was not sure whether the Kaiser report was available to the team at the time.

While the core staffing team concluded that claimant had communication and other problems, it did not believe that he exhibited those problems with the requisite degree of severity to warrant a diagnosis of autism for purposes of eligibility for regional center services. When Dr. Watson spoke with claimant during her participation in the CAST analysis, he was interactive. While he clearly had difficulties communicating, he interacted in a “somewhat appropriate way.” When Dr. Watson met with claimant and his parents for an informal meeting on July 14, 2010, after the CAST team’s assessments to discuss whether claimant was eligible for regional center services, claimant again was interactive and “quite charming.” Dr. Watson noted that claimant has always shown an interest in social interactions, but has had difficulties with them, in contrast to the characteristic lack of interest in social interactions displayed by those with Autistic Disorder. She did not observe any echolalia, hand flapping, spinning, or hair pulling on claimant’s part. The inconsistencies in claimant’s behaviors with the behaviors typically associated with autism thus suggested to her that he does not have Autistic Disorder.

26. Prior to the hearing, Dr. Watson reviewed the Kaiser report, but she disagreed that it demonstrates claimant has Autistic Disorder. She noted the inconsistencies in the various assessment test scores obtained by the Kaiser multidisciplinary team.

27. During her testimony, Dr. Watson reviewed the letter SCLARC sent denying claimant’s eligibility for regional center services (Exhibit 8) and explained that the CAST team focused on the degree of claimant’s difficulties. That letter notes that to be eligible for regional center services, a person must have a defined “developmental disability” that constitutes a “substantial disability” for the individual in three or more areas of major life activity. Dr. Watson reviewed the major life activities contained in the statutory criteria for finding a “substantial disability.” She testified that claimant has significant functional limitations with the area of receptive and expressive language, and some functional limitations with the area of learning, but his most recent IEP prior to the hearing reflects that he is improving in both areas. The core staffing team did not have that IEP available to it when it made the decision to deny claimant eligibility for regional center services, but Dr. Watson testified it reinforces the team’s decision. It reflects he has lots of friends in school, initiates conversation, and has no behavioral goals, all points inconsistent, in her opinion, with a diagnosis of Autistic Disorder. His language goals are consistent with goals often seen in autism, but they are also seen in children with language disorders or difficulties. Dr. Watson believes claimant suffers from learning problems (possibly arising out of Attention Deficit-Hyperactivity Disorder or another psychiatric disorder) and language problems. She opined that claimant does not suffer from significant functional limitations, considering his age, in the areas of self care, mobility or self-direction. Dr. Watson testified claimant will have the capacity for independent living (another major life activity) if he continues to improve. She noted that the functional area of economic self-sufficiency is not an appropriate area to consider in a child of claimant’s age. As a result, in her view, claimant does not have significant functional limitations in three or more of the requisite areas of major life activity.

28. During her testimony, Dr. Watson was, at times, unclear as to the diagnosis reached by the CAST team for claimant. That uncertainty appeared to be a function of the inconsistencies associated with the various observations and assessments of claimant and the lack of clarity associated with the nature of his disorders.

V. *Claimant's Parents' Testimony*

29. Claimant's parents were the only witnesses who testified on claimant's behalf during the hearing. Their testimony made clear that claimant's behaviors, sensitivities, and communication problems are very challenging, and they reiterated many of the observations and other information set forth in the school, Kaiser, and SCLARC reports. They testified that claimant's only friends are disabled children from his special education class and that other children will not play with him.

30. Although claimant's parents credibly testified as to the difficult nature of claimant's behaviors and communication and social problems, some of their testimony conflicted with the documentation presented on behalf of both parties. For example, claimant's father stated he first noticed some kind of disability in claimant when claimant was nine months old, based on the limited number of words claimant spoke and claimant's fear of relatives. This is in contrast to prior reports of claimant's normal speech development up to the age of two and one-half or three years of age. Claimant's parents also went into much greater detail about claimant's preoccupations, repetitive motor mannerisms, and auto-stimulatory, self-injurious, and ritualistic behaviors, and portrayed them as occurring more frequently or with greater severity, than was observed or recorded in the majority of the reports set forth above. Claimant's father's testimony about the extent of claimant's use of repetitive phrases (such as "I don't want to say it" being repeated 10-15 times in a row) was additionally different from the records presented. While it is understandable that claimant's parents might have been able to identify more behaviors as consistent with autism as they deepened their knowledge of autism, the number and extent of the inconsistencies was troubling.

31. Some of claimant's parent's testimony was doubtful for other reasons. For example, claimant's father contended that Dr. Walker spent only 40 minutes assessing claimant, when the report she prepared and the number of assessment tests she performed are likely inconsistent with such a brief appointment. There was no expert evidence, in any event, that the assessment period was insufficient. Claimant's father also suggested that some of the play and social skills observed by Dr. Walker had been taught to claimant by a little girl or claimant's brother, and he indicated that Dr. Walker's observation of such play and skills was somehow invalid as a result. However, this contention failed to recognize that play and social skills can be repeated and learned by children after observing them in others. Claimant's parents further sought to call Dr. Walker's assessment of claimant into question by stating that she raised her voice or yelled at claimant's mother when claimant's mother attempted to calm claimant down during a tantrum. Yet, there was no evidence that Dr. Walker had any reason to be hostile towards them, and their testimony indicated Dr. Walker was trying to observe claimant during a tantrum without parental involvement during this

interaction. Claimant's father suggested claimant's IEPs were inaccurate and failed to record claimant's need for behavioral services, but there was no evidence anyone was suggesting claimant needed such services at school once he was placed in a special education classroom. Claimant's advocate argued that Dr. Walker's assessment was improper because Dr. Walker communicated in Spanish without a certified interpreter; there was no evidence the Kaiser assessment was conducted with a certified interpreter or that a certified interpreter was needed.

V. Evaluation of Evidence

32. Findings 5a through 31 reflect that claimant has significant difficulties with language, communication, and acting in a socially appropriate way. Claimant certainly presents enormous challenges to his family. However, the various assessments by claimant's school district, Kaiser, and SCLARC fail to demonstrate that claimant suffers from Autistic Disorder or that he suffers from a "substantial disability" as defined by statute.

33. The DUSD reports and IEPs assessed claimant's behavior, cognitive abilities, and performance for purposes of his educational placement, not for eligibility for regional center services. There was no evidence that assessments performed for the DUSD were sufficient to diagnose claimant with Autistic Disorder under the DSM-IV-TR criteria. Moreover, claimant's most recent IEP indicates claimant has made substantial progress as a result of his educational placement and that his problematic behaviors and language problems have improved.

34. Although claimant was diagnosed with Autistic Disorder by Kaiser, the Kaiser report appeared to overstate some of claimant's behavior, language, and communication problems. The Kaiser report also included inconsistent results from the various assessment tools used and failed to consider some of the reports that were incompatible with a diagnosis of Autistic Disorder. Without anyone from Kaiser testifying about the assessment process, the reasoning behind the apparent overstatements in the Kaiser report or regarding the conclusion that claimant suffers from autism could not be explored or discussed. Nor could the variances among the different observations and reports be reconciled to support a diagnosis of autism.

35. Dr. Walker's assessment and testimony seemed, at times, to understate claimant's atypical communication and social skills. Nevertheless, the SCLARC assessment process was the most comprehensive and reliable, given the testimony of the persons involved and the various reports submitted in evidence. As explained by Dr. Walker, Ms. Craig-Douglas, and Dr. Watson, there were too many inconsistencies between claimant's observed behaviors and the diagnostic criteria for Autistic Disorder for a reliable diagnosis of autism to be made. Moreover, there are too many other possible explanations for his problematic behaviors and communication and social deficits to dependably conclude that claimant suffers from autism, as opposed to other disorders. Finally, as Dr. Watson's testimony demonstrated, claimant does not suffer from significant functional limitations in three or more of the requisite areas of major life activity. No one testified on claimant's

behalf to show he did suffer from functional limitations in three or more areas of major life activity.⁴

LEGAL CONCLUSIONS

1. Claimant is not eligible for regional center services for the reasons set forth in Factual Findings 1 through 35, and Legal Conclusions 2 through 10.

2. The party asserting a claim generally has the burden of proof in administrative proceedings. (See, e.g., *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789, fn. 9.) In this case, claimant bears the burden of proving, by a preponderance of the evidence, that he is eligible for government benefits or services. (See Evid. Code, § 115.)

3. To establish eligibility for regional center services under the Lanterman Act, claimant must show that he suffers from a developmental disability that “originate[d] before [he] attain[ed] 18 years old, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for [him].” (Welf. & Inst. Code, § 4512, subd. (a).) “Developmental disability” is defined to include mental retardation, cerebral palsy, epilepsy, autism, and “disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.” (*Id.*)

4. California Code of Regulations, title 17, section 54000, similarly defines “developmental disability” as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals. The disability must originate before age 18, be likely to continue indefinitely, and constitute a substantial handicap. Excluded are handicapping conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature.

5. The three exclusions from the definition of “developmental disability” under California Code of Regulations, title 17, section 54000, are further defined in that section. Solely psychiatric disorders involving impaired intellectual or social functioning which

⁴ While Dr. Tan’s letter of December 18, 2009 indicated he felt claimant did suffer from significant functional limitations in three or more areas of major life activity, that letter was based on a diagnosis of “Autism Spectrum Disorder,” rather than Autistic Disorder. (See Finding 19.) Because there is no DSM-IV-TR disorder by that name, and a diagnosis of Autistic Disorder is required for someone to suffer from autism under the Lanterman Act, it is unclear whether any conclusions regarding claimant’s functional limitations made by Kaiser in December of 2009 were based on a qualifying diagnosis. The Kaiser report from July 2010 does not include any conclusions regarding claimant’s functional limitations in the areas of major life activity.

originated as a result of the psychiatric disorders would not be considered developmental disabilities. “Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have been seriously impaired as an integral manifestation of the disorder.” (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1).)

6. Similarly, an individual would not be considered developmentally disabled if his or her only condition was a learning disability, “which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, [or] psychiatric disorder” (Cal. Code Regs., tit. 17, § 54000, subd. (c)(2).) Also excluded are solely physical conditions, such as faulty development not associated with a neurological impairment, that result in a need for treatment similar to that required for mental retardation.

7. For an individual with a developmental disability to qualify for regional center services, his or her developmental disability must also function as a “substantial disability.” The term “substantial disability” is defined in subdivision (1) of section 4512:

“‘Substantial disability’ means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: [¶] (1) Self-care. [¶] (2) Receptive and expressive language. [¶] (3) Learning. [¶] (4) Mobility. [¶] (5) Self-direction. [¶] (6) Capacity for independent living. [¶] (7) Economic self-sufficiency.” (See also Cal. Code Regs., tit. 17, § 54001, subd. (a).)

8. The determination of eligibility for services under the Lanterman Act is made by the regional center. “In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.” (Welf. & Inst. Code, § 4643, subd. (b).)

9. Claimant did not establish by a preponderance of the evidence that he has a qualifying diagnosis of autism. (Factual Findings 5a through 35.) As set forth at Findings 32 through 35, Service Agency's evidence was more persuasive than claimant's evidence and established that claimant does not have a qualifying condition under the Lanterman Act. (Welf. & Inst. Code, § 4512, subd. (a).) The DUSD reports and the Kaiser report were insufficient to refute the diagnoses by Dr. Walker or the conclusions of the CAST team, and they failed to establish a diagnosis of autism consistent with the DSM-IV-TR. (Factual Findings 5a through 35.)

10. Moreover, claimant failed to establish by a preponderance of the evidence that he suffers from significant functional limitations in three or more of the requisite areas of major life activity. (Factual Findings 27 and 35.)

11. Further testing and assessment may produce additional evidence that may be relevant to an eligibility determination. If so, appropriate action may be taken in the future. However, the evidence presented at the hearing of this matter was insufficient to establish claimant's eligibility for services from Service Agency.

ORDER

Claimant's appeal of Service Agency's determination that he is not eligible for regional center services is denied.

DATE: August 2, 2012

/s/

SUSAN L. FORMAKER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.