

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

VALLEY MOUNTAIN REGIONAL
CENTER,

Service Agency.

OAH No. 2013040234

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Stockton, California, on January 12, 2015.

The Service Agency, Valley Mountain Regional Center (VMRC), was represented by Anthony Hill, Assistant Director of Case Management.

Claimant was represented by her mother.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on January 12, 2015.

ISSUE

Is claimant eligible to receive regional center services and supports as an individual with intellectual disability pursuant to Welfare and Institutions Code section 4512?¹

¹Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

FACTUAL FINDINGS

1. Claimant is a four-year-old (58 months) girl who lives in the family home with her adoptive parents and siblings. At age eight months, she became eligible for California Early Start services after being referred due to concerns relating to reported prenatal drug exposure.

Claimant qualified for California Early Start services through VMRC pursuant to the California Early Intervention Services Act,² which provides early intervention services for infants and toddlers from birth to 36 months who have disabilities or are at risk of disabilities, to enhance their development and to minimize the potential for developmental delays. Her qualifying condition was noted as “global developmental delays.”

2. Claimant’s parents had early concerns regarding her muscle tone. The possible presence of cerebral palsy was considered and ruled out before claimant reached the age of two years, nine months. At hearing, the parties agreed that neither cerebral palsy nor fetal alcohol syndrome had been diagnosed.

3. On October 18, 2010, claimant’s first Individual Family Service Plan (IFSP) was completed. The IFSP Early Intervention programming included a comprehensive infant/teacher program with physical therapy services provided by Pediatric Milestones and funded by VMRC. The IFSP noted the family’s “priority (family’s choice of service focus & family issues affecting service delivery): Physical therapy.”

Subsequent IFSPs noted continuing concerns with muscle tone as well as speech. Claimant was referred to Tuolumne County California Children’s Services (CCS) which began providing Occupational Therapy (OT) and Physical Therapy (PT) Services.

Claimant was referred for a speech evaluation. The evaluator determined that claimant had deficits in expressive and receptive communication and her IFSP dated February 24, 2012 added speech therapy services, not to exceed five times per month, provided by Pediatric Milestones.

4. Eligibility for Early Start extends only until a child is three years of age. As claimant was approaching her third birthday in March of 2013, VMRC began transition planning. Claimant’s Early Start Transition Plan, dated November 7, 2012, included input from the Local Education Agency (LEA), Soulsbyville School District (Soulsbyville). The LEA is responsible for providing educationally - based services and supports after Early Start Services conclude. The transition plan included that the “LEA assessment team will schedule an IEP (Individualized Education Program) meeting with parents by 3/9/13.” The plan also notes that the parents requested an eligibility determination for ongoing VMRC services and supports under the Lanterman Act.

² California Government Code section 95000 et seq.

5. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500 et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines “developmental disability” as follows:

“Developmental disability” means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual.... [T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability [commonly known as the “fifth category”], but shall not include other handicapping conditions that are solely physical in nature.

6. California Code of Regulations, title 17, section 54000, further defines the term “developmental disability” as follows:

(a) “Developmental Disability” means a disability that is 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 individuals with mental retardation.

(b) The Development Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition 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, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

7. Welfare and Institutions Code section 4512, subdivision (1), defines “substantial disability” as:

(1) The existence of significant functional limitation 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.

8. California Code of Regulations, title 17, section 54001, provides:

(a) “Substantial disability” means:

(1) A condition which results in major impairment of cognitive and /or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of functional limitation, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person’s age:

- (1) Receptive and expressive language.
- (2) Learning.
- (3) Self-care.

- (4) Mobility.
- (5) Self-direction.
- (6) Capacity for independent living.
- (7) Economic self-sufficiency.

9. The VMRC Eligibility Team determined that claimant did not meet the eligibility criteria for regional center services. As a result of that determination, a Notice of Proposed Action (NOPA) was issued on March 7, 2013, informing claimant that VMRC determined she was not eligible for regional center services. The NOPA stated:

Proposed action: An interdisciplinary team composed of VMRC's clinical psychologist, physician, and service coordinator reviewed medical, psychological, and educational records and found your child ineligible for VMRC services.

Reason for action: The applicant does not have a substantially handicapping developmental disability.

10. Claimant's mother filed a Fair Hearing Request dated April 4, 2013, disputing claimant's ineligibility for regional center services. The reason for requesting a fair hearing was, "My child is being denied services. She meets the criteria for services as defined in Welfare and Institutions Code 4512. She has been diagnosed with mild cerebral palsy and global developmental delay. She has deficiencies in at least 4 areas: motor development, speech, cognitive delay, and global developmental delay."

Claimant's mother stated her desire that claimant "be accepted for services and to continue to receive benefits such as physical therapy, occupational therapy, speech therapy, assistance in preschool setting, and whatever other services she is eligible for."

11. At hearing, the parties testified that cerebral palsy had been ruled out for claimant. Therefore, the issue was whether claimant qualified for regional center services and supports based on the qualifying condition of intellectual disability.

12. An IFSP Service Summary was completed on March 5, 2013, in anticipation of claimant's exit from Early Start in March of 2013. Claimant's present levels of development were included based upon assessment results obtained through an evaluation of claimant which included administration of the Bayley Scales of Infant Development III (Bayley), Early Learning Accomplishment Profile (E-LAP), Receptive-Expressive Emergent Language Test (REEL 3), parent interview and observation.

At a chronological age of 34 months, Claimant received a cognitive development score with an age equivalency of 34 months.

13. The VMRC Interdisciplinary Review Team concluded that claimant was not eligible for regional services. "Over time, developmental skills have continued to progress and

are not suggestive of either MR³ or a condition similar to MR, as last measured at 34 months of age . . . Based on review of available information, [claimant] is not eligible for ongoing regional center services at this time.”

14. Claimant was referred to School Psychologist Shannon Casey, ED.S, MA, LEP, for a transitional assessment. Dr. Casey performed the evaluation on February 27, 2013 and issued her report on March 5, 2013. The reason for the referral included:

She was placed in the early start program due to global developmental delays. Current concerns are speech and motor development. Consultive query: does [claimant] qualify for special education services? If so, what is her primary Handicapping condition? What would be the least restrictive environment for her? What types of services does she require to be successful in school?

Dr. Casey concluded that claimant met the “criteria for special education under the handicapping condition of Other Health Impairment. She displays limited strength, vitality and alertness.” She also has “minor delays in social and communication domains.” She also noted that claimant “may benefit from speech therapy to address her delays in expressive communication and speech intelligibility.”

15. A Speech and Language Evaluation conducted as part of claimant’s initial evaluation for special education services concluded that “direct speech therapy services are recommended as well as enrollment in a general education preschool setting in order to provide [claimant] with good language and articulation age models.”

16. Claimant was originally found eligible for special education based on a Speech and Language Impairment (SLI). Later IEPs noted a primary eligibility of Other Health Impaired (OHI) and a secondary eligibility of Speech or Language Impairment (SLI). Goals were included in her IEP to “address the following areas of need: speech and language, preacademic, daily living, fine & gross motor.” There was no concern expressed related to an intellectual disability.

17. VMRC referred claimant to Educational Psychologist, Clinton J. Lukerth, Ed.D., “to obtain an assessment of her developmental status.” Dr. Lukerth administered the Differential Abilities Scale: Second Edition-Preschool (DAS-2) and the Adaptive Behavior Assessment System: Second Edition (ABAS-II).

³ Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” The terms are used interchangeably throughout.

The DAS-2 is a “comprehensive, individually administered, clinical instrument for assessing the cognitive abilities that are important to learning...the diagnostic subtests measure a variety of cognitive abilities including verbal and visual working memory, immediate and delayed recall, visual recognition and matching, processing and naming speed, and understanding of basic number concepts.”

On the DAS-2, claimant received a Verbal Score of 103, a Nonverbal Reasoning Score of 87, and a Spatial score of 90. Dr. Lukeroth concluded, “these results indicate that [claimant] is functioning in the average range of General Cognitive Ability (GCA).” On the DAS-2 subtests, claimant’s scores “place [claimant] in the average range of functioning for verbal activities and the low average range for nonverbal activities.

The ABAS-II is an adaptive behavior measure used to assess adaptive skills functioning utilizing rating forms. Claimant’s parent was the informant and reported a delayed range of adaptive functioning.

Dr. Lukeroth concluded as follows:

The current assessment results demonstrate that [claimant’s] abilities are in the average range on measures of verbal ability and the low average range on measures of nonverbal cognitive functioning.

[Claimant] does not demonstrate evidence of intellectual disability. Her verbal, ability, spatial ability, visual memory, and visual matching skills are average for her age. Her nonverbal reasoning and early math skills are low average. [Claimant’s] verbal memory is borderline and her adaptive behavioral functioning is deficient.

[Claimant’s] current test results are consistent with most of her former assessment results in demonstrating that she does not evidence global deficits. Severe cognitive delays have not been reported.

18. An Informal Meeting was held at VMRC on August 13, 2013. By letter dated August 13, 2013, Anthony Hill, VMRC Assistant Director of Case Management informed claimant’s mother of his determination to uphold the decision of the Eligibility Review Committee that claimant is not eligible for regional center services. Mr. Hill explained in part as follows:

Recent assessment findings yielded by standardized testing instruments reveal that your child does not have an intellectual disability as defined by Welfare and Institutions Code Section 4512(a) or Title 17 California Code of Regulations Section 54000.

The assessment findings over a course of time suggest that your child doesn't have an intellectual disability . . . There is evidence to support a finding that your child has an expressive language disorder and needs speech therapy services. However, an expressive language disorder is not defined as a developmental disability in WIC 4512(a).

19. Barbara Johnson Psy.D is a VMRC Clinical Psychologist with extensive experience conducting eligibility reviews. She testified that qualifying conditions for Early Start services are not the same as those required pursuant to the Lanterman Act, when a child reaches age three. Her review of claimant's eligibility included a complete records review. She testified that at eight, fourteen, and twenty months of age, claimant evidenced the possibility of an intellectual disability. By thirty months the concerns had resolved and there was no longer any evidence that claimant might be at risk of an intellectual disability.

To fully consider claimant's needs, Dr. Johnson "made a referral for a full assessment of cognitive functioning using a standardized measure." Dr. Lukeroth completed that assessment and determined that claimant does not demonstrate evidence of intellectual disability.

Dr. Johnson testified that to qualify for services under the Lanterman Act a consumer must possess one of the qualifying conditions and be substantially disabled. Deficits in adaptive skills alone are not sufficient.

20. Dr. Johnson testified that the diagnostic criteria for "Intellectual Disability" as set forth in section 4512 is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) as follows:

A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test...

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before 18 years.

21. The DSM-IV-TR includes the following explanation of diagnostic features:

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is

accompanied by significant limitations in adaptive functioning⁴ in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests . . . Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement of error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.

The DSM-IV-TR uses codes based on the degree of severity reflecting level of intellectual impairment:

317	Mild Mental Retardation:	IQ level 50-55 to approximately 70
318.0	Moderate Mental Retardation:	IQ level 35-40 to 50-55
318.1	Severe Mental Retardation:	IQ level 20-25 to 35-40
318.2	Profound Mental Retardation:	IQ level below 20 or 25

22. The DSM-IV-TR describes the elements of mild mental retardation in pertinent part as follows:

As a group, people with this level of Mental Retardation typically develop social and communication skill during the preschool

⁴ DSM-IV-TR states that “[a]daptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standard of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation.”

years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised setting.

23. The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V) was released in May 2013. Most notably, it changed the diagnosis Mental Retardation to Intellectual Disability (Intellectual Development Disorder)⁵ and no longer uses a multi-axial system. The new classification system combines the axes together and disorders are rated by severity.

The Diagnostic Criteria for Intellectual Disability in the DSM-V is set forth as follows:

Intellectual Disability (Intellectual Developmental Disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

⁵ The DSM-V further clarifies that the terms intellectual disability and mental retardation, as well as intellectual developmental disorder, are used interchangeably.

C. Onset of intellectual adaptive deficits during the developmental period.

24. The DSM-V offers the following pertinent diagnostic features:

The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers (Criterion B). Onset is during the developmental period (Criterion C). The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.

Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points. On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

[¶] . . . [¶]

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving and judgment in novel situations, among others. The *social domain* involves awareness of others' thoughts, feelings and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teacher; counselor; care provider) and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment . . .

Criterion B is met when at least one domain of adaptive functioning—conceptual, social or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, work, at home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Criterion C, onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

25. Claimant's mother testified to her concern that claimant's needs are not being met in the educational setting. She stated that claimant is not toilet trained, has melt downs, wakes in the night with leg cramps, cannot recognize her name, has difficulty with articulation, and does not understand social cues. She was also concerned that Dr. Lukeroth did not spend enough time in his assessment of claimant to obtain an accurate result.

26. Donald M. Olsen, M.D., Lucile Packard Children's Hospital, provided a letter dated December 31, 2013, outlining his impressions from claimant's visit on that date. He noted the continuing concerns with her low muscle tone and offered the following:

IMPRESSION: [Claimant] has developmental delay which may be a combination of intrauterine drug or alcohol exposure and possible genetic component. A specific genetic disorder is not identified.

She does not have any evidence of a progressive degenerative process or brain malformation. Her developmental delays at this point are primarily marked by her speech and mild to moderate cognitive delays, and her crude drawing and scribbling

She would benefit from continued work with speech therapy. In addition, the developmental help the school is giving her is quite appropriate.

I would add to that, occupational therapy evaluations once or twice a year. Depending upon the degree and type of deficits noted, she may or may not benefit from additional formal occupational therapy to work on fine motor coordination, visual motor integration and sensory motor integration. Many of these approaches can be done through the school classroom as well, particularly if OT is periodically monitoring [sic].

I think there is little benefit, at least at this point, from physical therapy. Though there is some clumsiness, likely related to her low tone, this can be addressed through more of an adaptive PE approach.

27. Dr. Olsen did not diagnose an Intellectual Disability.

28. On December 19, 2014, claimant was seen by Galyn M. Savage, Ph.D., at the Behavioral Health Clinic, Sonora Regional Medical Center. In her summary, Dr. Savage gave a diagnosis of expressive language impairment and developmental delay. She based her conclusions on the results obtained on the Burks' Behavior Rating Scales and the Adaptive Behavior Scale (ABS-P:2 and ABS-S:2) completed by claimant's mother and teacher. The

rating scales indicated deficits in adaptive functioning skills. There was no cognitive testing completed, no indication of an intellectual disability or that her adaptive functioning deficits are related to intellectual impairments.

29. Claimant did not meet the diagnostic criteria for intellectual disability under either the DSM-IV-TR or the DSM-V. Claimant has never qualified for educational services and supports as a student with intellectual disability. Adaptive skills assessments measure where claimant was functioning at the time of the assessment, not what caused the deficits. Adaptive functioning difficulties may result from many sources. There was no evidence that claimant's deficits in adaptive functioning are directly related to an intellectual impairment.

LEGAL CONCLUSIONS

1. Eligibility for regional center services is limited to those persons meeting the eligibility criteria for one of the five categories of developmental disabilities set forth in section 4512 as follows:

“Developmental disability” means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual.... [T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability [commonly known as the “fifth category”], but shall not include other handicapping conditions that consist solely physical in nature.

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act.

2. Claimant bears the burden of establishing that she meets the eligibility requirements for services under the Lanterman Act.⁶ She has not met that burden. Regional center services are limited to those individuals meeting the stated eligibility criteria. There was no evidence to support a finding of intellectual disability at this time. The evidence presented did not prove that claimant is currently substantially disabled by a qualifying condition that is

⁶ Neither the Lanterman Act nor its implementing regulations (Cal. Code Regs., tit. 17 § 50900 et seq.) assigns burden of proof. California Evidence Code section 500 states that “[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting.”

expected to continue indefinitely. Accordingly, claimant does not have a developmental disability as defined by the Lanterman Act and she is not eligible for regional center services at this time.

ORDER

Claimant's appeal from the Valley Mountain Regional Center's denial of eligibility for services is denied. Claimant is not eligible for regional center services under the Lanterman Act at this time.

DATED: January 26, 2015

_____/s/
SUSAN H. HOLLINGSHEAD
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)