

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

ALTA CALIFORNIA REGIONAL
CENTER,

Service Agency.

OAH No. 2013070363

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Sacramento, California, on January 27, 28, and 29, 2014.

The Service Agency, Alta California Regional Center (ACRC), was represented by Robin Black, Legal Services Manager.

Daphne L. Macklin, Attorney at Law, represented claimant.

Oral and documentary evidence was received. Submission of this matter was deferred pending receipt of closing briefs. Service Agency's Closing Brief and Claimant's Post Hearing Opening Brief were submitted on February 12, 2014, and February 13, 2014, and marked respectively as Exhibits 39 and B. On February 14, 2014, ACRC submitted objections to records and information contained in claimant's Post Hearing Opening Brief, which was marked as exhibit 40. On the same date, claimant submitted a response to the agency's objections which was marked as exhibit C. Service Agency's Rebuttal Brief and corrected page 15 to Rebuttal Brief were submitted on February 28, 2014, and marked respectively as Exhibits 41 and 42. Claimant's untitled 15 page closing document was submitted on March 3, 2014 and marked as exhibit D.

The record was closed and the matter submitted for decision on March 3, 2014.¹

¹ Any new evidence provided to OAH after conclusion of the hearing that was not presented at hearing and subject to cross-examination, was not considered for this decision.

ISSUES

Is claimant eligible to receive regional center services and supports as an individual with autism pursuant to Welfare and Institutions Code section 4512?²

In the alternative, is claimant eligible under the “fifth category” because he has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with intellectual disability?

FACTUAL FINDINGS

1. Claimant is a soon to turn twelve-year-old boy who resides in the family home with his parents and younger brother. He has two adult maternal half siblings that reside outside of the family home. Claimant’s youngest brother has been diagnosed with autism and is an ACRC client. Claimant’s mother requested an evaluation to determine claimant’s eligibility for regional center services and supports.

2. Records indicate he has had various medical concerns and diagnoses. Claimant was born prematurely; delivered at 35-6/7 weeks with a birth weight of 7 pounds, 11 ounces. He was noted to have experienced possible seizures as a young child, tracheomalacia,³ mild sleep apnea, difficulties falling and staying asleep, asthma and breathing related concerns, heart murmur, headaches, gastrointestinal issues, including failure to thrive as an infant, gastroesophageal reflux disease (GERD), and episodes of constipation alternating with diarrhea.

Claimant was born with moderate to severe bilateral hearing loss and received early intervention services to address this condition. When ventilation tubes were placed in his ears as a toddler, an abnormality of the inner ear was detected and surgically repaired. Following the surgery, his hearing improved considerably and presently he exhibits only mild hearing loss.

His primary medical concern was noted to be Chiari Malformation (Type 1), which was apparently surgically corrected with decompression surgery in 2011.

Claimant has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) for which he has been prescribed medications at various times.

²Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

³Tracheomalacia in an infant occurs when the cartilage in the trachea has not properly developed and results in a weakness or floppiness of the cartilage, which may cause breathing difficulties. The condition generally goes away on its own as the tracheal cartilage grows and gets stronger.

3. ACRC Intake Counselor Stan Gamba, MSW, conducted a social assessment of claimant on March 5, 2013, and April 15, 2013, which included interviews with claimant and his mother. As a result of this social assessment, ACRC referred claimant to Clinical Psychologist Monica Silva, Ph.D., a regional center vendor, for further evaluation. Dr. Silva completed her evaluation on May 3, 2013.

4. On May 28, 2013, the ACRC eligibility team, which included ACRC Staff Psychologist Cynthia Root, Ph.D., Staff Physician Terrance Wardinsky M.D., and Intake Counselor Mr. Gamba, determined that claimant was not eligible for regional center services.

5. As a result of the eligibility team determination, A Notice of Proposed Action (NOPA) was issued on May 28, 2013, informing claimant that ACRC determined he was not eligible for regional center services. The NOPA stated:

Reason for action: On 5/28/23, the ACRC eligibility team determined [claimant] is not eligible for regional center services because he does not have a developmental disability as defined by the Lanterman Act. Specifically, [claimant] does not have autism, Intellectual Disability/Mental Retardation, or a disabling condition closely related to an Intellectual Disability/Mental Retardation or which requires treatment similar to that required for an Intellectually Disable/Mentally Retarded individual. In addition, there is no evidence that [claimant] has epilepsy or cerebral palsy.

The information considered by the team in making this decision includes all information and records provided to the Regional Center, including but not limited to:

ACRC Social assessment on 3/5 and 4/15/13 By Stan Gamba, MSW
Psychological evaluation on 5/11/11 by Travis Owens, Psy.D. with Valley Psychological Center
Psychoeducational evaluation in 04-05/2012 by Peggy Holcomb, MS, MA, LED, Clinical Psychology Doctoral Candidate with Center for Neurobehavioral Development
Psychological evaluation on 5/3/13 by Monica Silva, Ph.D.⁴
Educational/Medical records provided to the regional center

6. Mr. Gamba enclosed the NOPA with a letter of the same date to claimant's mother including further explanation:

The ID⁵ Team reported [claimant] has cognitive abilities in the average to high average range. In addition, he does not warrant a

⁴ This line of text and the prior line were reversed in original.

diagnosis of autism. Furthermore, there is no evidence to suggest [claimant] has epilepsy or cerebral palsy. Because [claimant] does not meet the criteria for a developmental disability as defined by the Lanterman Act (intellectual disability/mental retardation or autism), he has been determined not eligible for ACRC. Dr. Silva diagnosed [claimant] with Attention Deficit Hyperactivity Disorder (by history) and recommended an evaluation to rule out Sensory Integration Disorder. Furthermore, Dr. Silva made several recommendations for treatment purposes and a copy of her report is attached . . .

7. Claimant filed a Fair Hearing Request, Dated July 1, 2013, disputing his ineligibility for regional center services. The reason for requesting a fair hearing was because “[claimant’s mother] has raised serious objections to the adequacy of Dr. Silva’s report. The child’s physical medical (neurological) conditions have contributed to significant developmental and behavioral impairments.”

The request sought “[a]n evaluation by a qualified psychologist; a more thorough review of the impact of the child’s medical and developmental impairments.”

8. An Informal Meeting was held on October 3, 2013, with the following persons present:

[Claimant’s mother]
Daphne Macklin, [claimant’s] Attorney
Stan Gamba, ACRC Intake Counselor
Cynthia Root, Ph.D., ACRC Staff Psychologist
Sindhu Philip, Psy. D., ACRC Staff Psychologist
Robin Black, ACRC Legal Services Manager and Designee of ACRC Executive Director

ACRC Designee Ms. Black upheld ACRC’s determination that claimant is not eligible for regional center services. She also determined that “good cause does not exist for ACRC to fund or obtain a new psychological evaluation of [claimant] for the purposes of determining his eligibility.”

9. 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

⁵ Interdisciplinary Team.

intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability⁶ 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.

10. 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.

⁶ Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” The terms are used interchangeably throughout.

(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.

11. Welfare and Institutions Code section 4512, subdivision (l), defines substantial disability as:

(l) 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.

12. 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.

13. As a result of claimant's social assessment, he was referred by ACRC to Licensed Clinical Psychologist Monica Silva, Ph.D. Dr. Silva has been in practice for over

twenty years and has been vendored with the regional center for approximately nine years. She testified that her current practice consists primarily of conducting clinical evaluations to assess individuals for the presence of developmental disabilities. Her previous experience also includes five years as a School Psychologist. Dr. Silva's May 3, 2013 report noted the following:

REASON FOR REFERRAL

[Claimant] was referred by intake counselor Stan Gamba, MSW, for an evaluation of adaptive and behavioral skills in order to determine eligibility. It is suspected he presents with characteristics of an Autism Spectrum Disorder. The following evaluation will summarize [Claimant's] current cognitive, adaptive, and behavioral functioning and evaluate for the possibility of a Developmental Disorder.

14. For this evaluation, Dr. Silva performed a record review, interviewed claimant's mother, made behavioral observations and administered the Autistic Diagnostic Observation Schedule-Second Edition (ADOS-2) Module III, and the Adaptive Behavior Assessment System, Second Edition (ABAS-II) Parent Form.

15. Dr. Silva's report stated "the ADOS-2 is a standardized, semi-structured observation assessment tool which allows examiners to observe and gather information regarding an individual's social behavior and communication in a variety of different social communication situations. Significant scores do not automatically imply that an individual has autism but that its presence is a reasonable possibility. Module III was utilized based on [claimant's] verbal abilities." The ADOS is considered the "Gold Standard" instrument used in the assessment of autism.

Claimant "demonstrated the capacity for fluent speech and was therefore administered Module III of the ADOS-2. He maintained an upbeat, exuberant, and cooperative attitude and completed the routines of the ADOS-2 without issues. Given his talkative nature, the administration of the ADOS-2 took longer than with most individuals his age." Claimant presented "as a friendly child who seemed immediately at ease engaging with an unfamiliar adult."

16. Dr. Silva concluded that "[claimant's] ADOS-2 score did not meet or exceed the Autism Cutoff or the Autism Spectrum Cutoff and was consistent with an ADOS-2 Nonspectrum classification [SA = 3, RRB = 1, SA+ RRB = 4, CS = 2 (Autism Overall Total Cutoff Score = 9, Autism Spectrum Overall Total Cutoff Score = 7)]."⁷

⁷ Claimant's total score was four as shown through the combined totals of "social affect" (SA) and "restrictive, repetitive behaviors" (RRB). Comparison score (CS) reflects comparison scoring with others his age.

17. The ABAS-II is a “standardized instrument of adaptive functioning. The focus of this instrument is on the functions an individual performs without the assistance of others.” Claimant’s mother completed the ABAS-II using the Parent Form, which resulted in the following scores:

<u>GAC and Domain Composite Scores</u>	<u>Standard Score</u>	<u>Percentile Rank</u>
General Adaptive Composite	42	<0.1
Conceptual	51	0.1
Social	53	0.1
Practical	41	<0.1

18. Dr. Silva noted that claimant “experienced moderate to severe hearing loss as a young child and his speech was delayed. Currently, he communicates fluently and displays a strong vocabulary though he exhibits some ‘idiosyncrasies’ in his speech and language use. He has been diagnosed with ADHD and severe deficits in executive functioning.” Currently, he is prescribed Intuniv to assist with focus and tics; Adderall to “manage symptoms of Attention Deficit Hyperactivity Disorder and Executive Dysfunction...”

“There is a strong history of Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder on both sides of his family, as [claimant’s] parents and his 20-year-old brother have been diagnosed. There is also a history of autism on the paternal side of the family, and [claimant’s] 5-year-old brother has been diagnosed with Autism and Attention Deficit Hyperactivity Disorder.”

19. Dr. Silva’s report explained that claimant’s “cognitive abilities had been evaluated on two consecutive years yielding similar results and there were no concerns regarding his cognitive potential; on the contrary, he was described as a bright child with superior verbal skills. Therefore, there was no further cognitive assessment completed during the current evaluation. . .”

20. Dr. Silva concluded that claimant “does not present with the global delays in cognition characteristic of an Intellectual Disability (formally Mental Retardation) or Borderline Intellectual Functioning. He presents with symptoms of Executive Dysfunction which likely impact his day-to-day adaptive abilities.” In her opinion, “though [claimant] presents with difficulties relating to peers and mild idiosyncrasies in language and behavior, he does not present with the marked atypicalities and impairments in socialization, communication, and stereotyped behaviors and restricted interests characteristic of Autistic Disorder. A diagnosis of Asperger’s Disorder is ruled out by early language delays” and “a diagnosis of Pervasive Developmental Disorder-Not Otherwise Specified is ruled out by [claimant’s] strong socialization abilities and desire to interact with peers. In this examiner’s opinion, his idiosyncrasies in peer relations are likely related to a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and the issues with Executive Dysfunction typically experienced by individuals diagnosed with that disorder.”

21. In addition to symptoms of ADHD, Dr. Silva noted concerns with sensory integration issues, which she described as follows:

Children who struggle with sensory integration issues can also exhibit significant issues with communication and socialization. In addition, they have a tendency to be easily distracted, exhibit limited attention control, demonstrate impulsivity and lack of self-control, and show an unusually high activity level. Moreover, children with sensory integration dysfunction may face challenges that affect their play and socialization skills, such as coping with noise and groups of children. Children with sensory issues have difficulty processing everyday sensations and they may exhibit unusual behaviors such as avoiding touch, movement, sounds, and sights. Sensory integration issues can support behaviors such as tantruming and withdrawal from over-stimulating environment.

22. Dr. Silva's report offered the following:

DSM-IV-TR ⁸ DIAGNOSES

Axis I	Attention Deficit Hyperactivity Disorder (By History)
Axis II	No Diagnosis on Axis II
Axis III	Rule Out Sensory Integration Disorder
Axis IV	Social and Educational Issues
Axis V	GAF: 60

23. As part of her evaluation, Dr. Silva also considered the reports of Dr. Travis Owens and Ms. Peggy Holcomb.

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⁸ The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) was the standard for diagnosis and classification at the time of this assessment. It is a multi-axial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

24. Licensed Psychologist Travis H. Owens, Psy.D., completed a psychological evaluation of claimant on May 11, 2011. Dr. Owens report included:

REASON FOR REFERRAL

[Claimant] is a nine year-old, Caucasian male referred by the Department of Social Services, Disability Evaluation Division, for a psychological evaluation. [Claimant's] mother stated that his disability is "autism and a Chiari malformation and ADHD and some oral, motor tics." [Claimant's] mother reported that his autism was initially diagnosed March 30, 2011.

25. As part of this evaluation, Dr. Owens administered the Wechsler Intelligence Scale For Children-IV (WISC-IV), which consists of a series of subtests that are used to assess an individual in four major domains of intelligence and offer a summary of general intellectual abilities. The four Composite Index Scales are Verbal Comprehension Index (VCI), Perceptual Reasoning Index (PRI), Working Memory Index (WMI), and the Processing Speed Index (PSI). Dr. Owens noted the following results:

Scale	Composite Score
Verbal Comprehension	119 (High Average)
Perceptual Reasoning	106 (Average)
Working Memory	94 (Average)
Processing Speed	97 (Average)
Full Scale IQ	108 (Average)

26. To assess claimant's adaptive behavior, Dr. Owens utilized the Vineland Adaptive Behavior Scales-Second Edition (VABS-2). The VABS-2 measures adaptive behavior, not what an individual is capable of but actual performance, and was used to assess adaptive behavior in the domains of Communication, Daily Living Skills, and Socialization. The Adaptive Behavior Composite Score summarizes claimant's performance across all domains. Claimant's mother completed the VABS-2 rating scale, and the results indicated that claimant's overall level of adaptive behavior skills falls below the first percentile and in the Low range when compared with individuals his age.

Domain	Standard Score
Communication	54
Daily Living Skills	63
Socialization	57
Adaptive Behavior Composite	59

Dr. Owens noted “[claimant] appears to be maturing and developing at a rate significantly slower than other children his age. It should be noted that during the interview his communication skills appeared to be better than indicated by the 54 on this test.”

27. Dr. Owens concluded as follows:

DIAGNOSIS

The evidence from this evaluation points to the following DSM-IV diagnoses:

Axis I	299.00	Autistic Disorder (per history)
	314.01	Attention Deficit Hyperactivity Disorder Combined (per history)
Axis II		No Diagnosis
Axis III		Chiari malformation, hearing impairment, Convulsions
Axis IV		Psychological Stressors: Limited support group
Axis V		Current GAF: 55

28. Dr. Owens did not testify at the hearing in this matter.

29. Licensed Educational Psychologist, Peggy Holcomb, M.S., M.A.,⁹ completed a psychoeducational evaluation of claimant during April and May 2012. The “Nature of Referral” stated:

The present assessment was requested by [claimant’s mother] who stated that the last psychoeducational evaluation (report dated 5/15/11), conducted by an Independent Evaluator who was contracted by the South Sutter Charter Schools in Placerville, California, resulted in an “inaccurate and inappropriate” portrayal of [claimant]. Further, it was reported by [claimant’s mother] that the present assessment/psychoeducational report is intended to replace the 5/15/11 psychoeducational report which has been or will soon be removed from the records.

It was requested that I evaluate [claimant] in three areas: academic achievement, intellectual development, and social/emotional functioning, per the assessment plan, dated 2/6/12.

⁹ Ms. Holcomb’s report indicated that she was a “Clinical Psychology Doctoral Candidate” at the time of the evaluation. No evidence was presented to establish whether or not she completed that course of study and/or became licensed as a Clinical Psychologist.

30. The Evaluation Report began with a note that included the following information:

This evaluation should not be placed within the child's cumulative educational file but should be kept under lock and key and shared only with those professionals with a valid interest in the education of the child. Additionally, it is expressly understood that the sole purpose of this evaluation was to determine the student's current level of academic achievement, cognitive/intellectual functioning, and social/emotional/behavioral status. *The evaluation was conducted for the specific purpose of establishing eligibility for special education services pursuant to the California Education Code (Ed. Code) and the Individuals with Disabilities Education Improvement Act (IDEIA). The current evaluation is not intended for use in other matters (i.e., establishing eligibility for SSI, eligibility under the Lanterman Act, child custody/forensic issues, etc).* . . .
(Emphasis added.)

31. Ms. Holcomb's report stated that claimant was diagnosed with autism on March 30, 2011, by pediatric neurologist Dr. Michael Chez, just weeks prior to the 5/18/11 IEP.¹⁰ Dr. Chez reported that claimant meets "criteria for high functioning autism" and also has "ADHD (314.10) issues. (Note: The diagnostic code of '314.10' is used for individuals who have both inattentive and hyperactive features, rather than either inattentiveness or hyperactivity, alone)."

The report stated that the May 18, 2011 IEP indicated that claimant was "eligible for special education services under two separate and distinct qualifying conditions. [Claimant's] 'Primary' disability is reported to be due to a Specific Learning Disability (SLD). As noted in his IEP, his reading comprehension skills and written expression skills are adversely impacted by an attention processing disorder, thereby qualifying him as a student with a SLD. He is also designated as a student with 'Autism' which was coded in the IEP as [claimant's] 'Secondary' disability."

"Finally, it was noted in the most recent IEP records that the Independent Evaluator and Licensed Educational Psychologist who completed the May 2010 and May 2011 psychological evaluations did not conduct a thorough evaluation to address concerns regarding the presence of autism or 'autistic-like' behaviors but concluded that [claimant] did not meet special education criteria to be classified as a student with 'autistic-like' behavior."

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¹⁰ Individualized Education Program.

32. Ms. Holcomb conducted extensive interviews and observations as well as administering a variety of assessment instruments. On the Wechsler Intelligence Scale for Children, 4th Edition (WISC-IV), claimant achieved the following scores:

Composite	Standard Score
Verbal Comprehension	126 (114)
Perceptual Reasoning	94 (90)
Working Memory	88 (97)
Processing Speed	91 (91)
FSIQ	102 (99)

For comparison, Ms. Holcomb included the scores from a March 2011 assessment conducted by school psychologist, Ms. Balcao, in parentheses. In summary, she concluded that claimant has a scattered profile with a marked strength in his ability to solve problems with language. She opined that his “intellectual ability is best estimated by his very strong verbal skills (WISC-IV Verbal Comprehension SS=126). . .”

33. Claimant’s scores on the Wechsler Individual Achievement Test, Second Edition (WIAT-II) were as follows:

<i>Subtest/Composite</i>	Standard Score
Word Reading	90
Reading Comprehension	86
Pseudoword Decoding	88
<i>Reading Composite</i>	85
Numerical Operations	102
Math Reasoning	112
<i>Mathematics Composite</i>	107
Spelling	75
Written Expression	78
<i>Written Language</i>	78

In explaining these results, Ms. Holcomb stated “[Claimant’s] math skills are relatively strong (Mathematics Composite SS=107) while his reading skills remain weak (Reading Composite SS=85). More concerning, however, are his written language skills, however which are in the below average range (Written Language Composite SS=78). Given the 41-point discrepancy between [claimant’s] verbal problem-solving skills (WISC-IV VCI=126) and his reading skills (WIAT-II SS=85) as well as the 48-point discrepancy between his verbal skills and written language skills (WIAT-II SS=78), [Claimant] requires focused, prescriptive intervention strategies to address his poorly developed language arts skills.”

34. The Vineland Adaptive Behavior Scales-Second Edition rating scales were completed by claimant’s mother and teacher with the following results:

Domain/Subdomain	Standard Score (SS)/v-scale score Percentile			
	Parent(P)	Teacher(T)	(P)	(T)
Communication	62 (SS)	96 (SS)	1	39th
<i>Receptive Language</i>	7	14		
<i>Expressive Language</i>	8	15		
<i>Written Language</i>	9	15		
Daily Living Skills	58 (SS)	108 (SS)	<1	70th
<i>Personal</i>	9	16		
<i>Domestic</i>	5	19		
<i>Communication</i>	7	14		
Socialization	62 (SS)	110 (SS)	1	51st
<i>Interpersonal Relationships</i>	7	13		
<i>Play and Leisure Time</i>	7	14		
<i>Coping Skills</i>	11	14		
<i>Adaptive Behavior Composite</i>	60 (SS)	105 (SS)	<1	63rd

Ms. Holcomb’s report explained “that v-scale scores from 12-18 are “adequate” while scores from 9-11 indicate moderately low skills and scores <9 indicate deficit areas . . .Domain Standard Scores (SS) of 85-115 indicate generally adequate performance while scores from 70-84 suggest moderately low performance and scores <70 highlight areas in need of intervention.”

In addressing the scores, Ms. Holcomb stated that claimant’s mother “reported that [claimant] has very significant difficulty with: hyperactivity; anxiety; atypical/odd behaviors; attention problems; social skills; functional communication skills and activities of daily living. She also reported that he has difficulty with depression; withdrawal; adaptability/coping; leadership/being independent.” While claimant’s teacher “reported that [claimant] functions well in the educational setting, overall. She noted mild problems in the areas of social skills; study skills; and functional communication, all of which are commonly reported in children with various conditions such as ADHD, learning disabilities, and pervasive developmental disorders such as autism or Asperger’s Disorder.”

35. In addition, claimant’s mother apparently reported on a Pervasive Developmental Disorders Behavior Inventory (PDDBI) parent form, claimant’s behaviors that are “consistent with children who carry a DSM-IV-TR diagnosis of autistic disorder.”

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36. Ms. Holcomb administered the ADOS, Module 3 and reported as follows:

On the Communication scale, [Claimant] received a score of two (2) where the autism spectrum cut-off score is (2) and the autism cutoff is three (3). On the Reciprocal Social Interaction scale he obtained a score of five (5) where the autism cut-off score is four (4) and the autism cut-off is six (6). Taken together, he received a Combined score of seven (7) where the autism spectrum cut-off score is seven (7) and the autism cut-off is ten (10). Thus, results indicate that [claimant] meets criteria as a child with an autism spectrum disorder.

Children with scores of ten (10) or greater are generally regarded as meeting full criteria for autism. Based on the current assessment, [claimant] does not meet criteria for “classic” autism but he does meet criteria for the broader autism spectrum. . . Ed. Code will continue to serve as the authoritative resource used to determine eligibility for special education services under the “autistic-like” category.

37. Based on her evaluation of claimant, Ms. Holcomb concluded that he met the criteria “as ‘autistic-like’ for special education services” pursuant to “Section 3030 (G) of Title 5 of The California Education Code of Regulations”¹¹ which states:

(a) A “pupil with autism” is a pupil who exhibits autistic-like behaviors, including but not limited to, any of the following behaviors, or any combination thereof:

(1) An inability to use oral language for appropriate communication.

(2) A history of extreme withdrawal or of relating to people inappropriately, and continued impairment in social interaction from infancy through early childhood.

(3) An obsession to maintain sameness.

(4) Extreme preoccupation with objects, inappropriate use of objects, or both.

(5) Extreme resistance to controls.

(6) A display of peculiar motoric mannerisms and motility patterns.

(7) Self-stimulating, ritualistic behavior.

38. Ms. Holcomb concluded that in addition to meeting the “autistic-like” criteria for special education services, he also “continues to show evidence of struggling with a learning disability, as identified by Ms. Balcao in her previous assessment. She concluded as follows:

¹¹ California Code of Regulations, title 5, section 3030, subdivision (g).

Continued support in reading, reading comprehension, and written expression is recommended. Additionally, support in developing more age appropriate pragmatic language and social skills will go a long way in furthering [claimant's] ability to have, establish and maintain peer relations and overall communication skills necessary to succeed not only in school but in daily living/community settings. Given his strong verbal skills, a group format would be particularly beneficial in learning social skills and practicing pragmatic language.

. . . it is recommended that the IEP team consider all relevant information in order to draft relevant, meaningful IEP goals designed to assist [claimant] in improving his language arts skills. Strong consideration should be given to transitioning [claimant] to a traditional, full day, inclusive school setting so that he has sufficient opportunities to access the curriculum and learn/apply more age appropriate social skills.

39. Ms. Holcomb did not testify at the hearing in this matter.

40. Claimant's mother testified that she become concerned about claimant's behaviors as an infant and young child. She described a difficult pregnancy, claimant's premature birth and subsequent medical concerns. Due to his moderate to severe deafness at a young age, she worked with him using American Sign Language (ASL) and PECS (Picture Exchange Communication System) as alternative forms of language acquisition. After his ear surgery and improved hearing, his language and communication skills developed exponentially. However, she has continuing concerns with his social/pragmatic language skills.

She testified that claimant has poor social skills and has no friends. He may think that he has friends, but he is never invited to sleepovers nor are invitations to peers accepted. When he has a birthday party, she stated that very few children will attend and those who do attend do so because she has made the request to their parents. While he is "engaging and friendly" with adults, peer relationships are more difficult. She explained that he has also had communication difficulties ordering at a fast food restaurant without assistance.

41. Claimant's mother stated that he has a sensory integration disorder which results in an ongoing struggle wearing clothes due to tactile and texture concerns. He also has difficulty with noise. Claimant has difficulty with fine motor skills, such as signing his name in cursive, and requires prompting for completing self-care and chores.

42. Claimant's mother strongly disagreed with Dr. Silva's conclusions and had serious objections to the assessment itself. As a result, she filed an eleven page, single-spaced complaint with ACRC, the "ACRC Board Members" and "The Psychology Board and the State of California Department of Consumer Affairs." Her concerns were considered for this decision.

43. Claimant's mother contends that claimant should be eligible for regional center services because "he has had a confirmed autism diagnosis for years." She testified that Dr. Chez made the original diagnosis on March 30, 2011. In the alternative, she believes he should qualify under the fifth category. She stated that her understanding is that the fifth category is a "catch all area if a child has health issues, physical issues, psychiatric issues, not just in one area but in multiple areas and they might not fit into cerebral palsy or autism or one of the specific categories."

She also contends that claimant's "developmental issues were so serious that he was evaluated and approved for services through ACRC's early intervention program at age five months."

44. Claimant qualified for California Early Start services through ACRC, pursuant to the California Early Intervention Services Act¹² which provides early intervention services for infants and toddlers from birth to two years of age, inclusive, who have disabilities or are at risk of disabilities, to enhance their development and to minimize the potential for developmental delays. This early intervention program is separate from, and does not have the same requirements as, the Lanterman Act. The eligibility criteria for an infant or toddler to receive early intervention services do not require a developmental disability. What is required is at least a 33 percent delay in one of the five following areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; or adaptive development.

Claimant's initial Individualized Family Service Plan (IFSP) dated November 4, 2002, indicates that claimant was found eligible for services under the California Early Start Program based on a "Solely Low Incidence" . . . "Hearing Impairment."

45. There are limited educational records in evidence. Claimant's mother testified that subsequent to early intervention services, at age three claimant began attending a preschool with a focus on children who were deaf and hard of hearing. After his ear surgery and subsequent hearing, claimant transferred to a regular Head Start program. Claimant began kindergarten in a regular education classroom where his mother testified that he was placed in a forty minute "time-out" due to his behaviors and inability to follow directions. His parents determined that the school district failed to meet claimant's needs appropriately and they chose to home school him at that time, through a charter school program. He has continued to be home schooled to date. His parents have supplemented his education with tutoring, athletics, and other activities intended to provide socialization opportunities. In addition, he has received various special education services and supports provided through his local education agency.

The only Individualized Education Program (IEP) in the record, dated August 20, 2012, indicates that claimant's primary and secondary disabilities were changed to a primary of Autism and secondary of Specific Learning Disability. The IEP states that claimant "meets eligibility criteria as a student with Autistic Like Behaviors and is also eligible to receive special

¹² California Government Code Section 95000 et seq.

education services due to a Specific Learning Disability. A severe discrepancy between intellectual ability and academic achievement has been identified within the areas of reading comprehension and written expression. A processing disorder has been identified within the area of attention.”

46. In addition, claimant’s mother contends that he has benefitted from Applied Behavioral Analysis (ABA) Services provided for his younger brother who has autism. There was no evidence presented to show that claimant required or received ABA services. Learning Solutions, claimant’s brother’s ABA provider explained the following in a letter dated March 29, 2011:

Learning Solutions is currently providing Applied Behavioral Analysis Services for [claimant’s brother]. These services include parent training. Training targets include, but are not limited to: operationally defining behavior; collecting antecedent, behavior, consequence data, and collecting frequency data.

[Claimant’s mother] used the above described strategies to collect data pertinent to her son [claimant’s] behaviors.

Eligibility Based on Autism/Autism Spectrum Disorder

47. DSM-IV-TR¹³ section 299.00, Autistic Disorder, states:

The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual... The impairment in reciprocal social interaction is gross and sustained . . . The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills.

To diagnose Autistic Disorder, it must be determined that an individual has at least two qualitative impairments in social interaction; at least one qualitative impairment in communication; and at least one restricted repetitive and stereotyped pattern of behavior, interests, or activities. One must have a combined

¹³ The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-V) was released in May 2013. The plain language of the Lanterman Act’s eligibility categories includes “autism” but does not include other PDD diagnoses in the DSM-IV-TR (Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and PDD-NOS.) The Lanterman Act has not been revised since the publication of the DSM-V to reflect the current terminology of Autism Spectrum Disorder. Claimant was diagnosed under the DSM-IV-TR.

minimum of six items from these three categories. In addition, delays or abnormal functioning in at least one of the following areas, with onset prior to age three, is required: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

48. Claimant's mother testified that he was diagnosed with autism in March 2011, at age nine, by his pediatric neurologist, Michael Chez, M.D. A letter from Dr. Chez dated March 30, 2011, addressed "To Whom it may concern," stated the following:

Patient has criteria for high functioning autism clinically 299.00 and also ADHD 314.10 issues. He has complex issues medically including headaches, intermittent nystagmus, tics, and Chiari Malformation.

49. Progress notes completed after an office visit with claimant on the same date included the following pertinent information:

SUBJECTIVE:

[Claimant] is a 9 year old male who presents today for follow up of their [sic] headaches and also problems with eye nystagmus

EEG was normal

MRI shows CHIARI

Also tongue dermoid cyst

Suggest refer neurosurgery

Also has hearing issues from chronic infections which caused speech delays

Autism CARS and OASIS aspergers were positive

Also positive Connors and Vanderbilt teacher and Mom

Consistent with Asperger high functioning autism and ADHD

Discuss need to possibly treat these issues

Tics

Headaches occur infrequently

Eye twitching occurs with and without headache mother describes

involuntary nystagmus

Patient has vocal tics too

Chiari noted not too bad but may be causing some of these symptoms

ASSESSMENT:

Autism spectrum patient with high functioning

Also has clear impulse and ADHD issues

Discuss risk factors for stimulant vs tenex trial

May try stimulant

Family history schizophrenia and autism and ADHD

Family needs neurosurgical opinion on chiari
Also ENT or oral surgery to check tongue
Also cardiology issues in past murmur not hear now
Needs EKG and perhaps echo before the trial any meds in future
for ADHD

The March 30, 2011, Progress Notes also reference scanning the following questionnaires:

“C.A.R.S. FORM; OASIS FORM; VANDERBILT TEACHER RATING SCALE; VANDERBILT PARENT RATING SCALE; CONNERS FORMS.”

50. Dr. Chez did not testify at hearing, but his records suggest the possibility of treating claimant’s ADHD with medication. He also recommended a surgical consultation to consider treatment of the Chiari Malformation.

51. A letter dated August 8, 2011 signed by Dr. Chez’s Nurse Practitioner, Susan Caffrey, noted that claimant was “post decompression surgery.” By letter dated September 25, 2013, Ms. Caffrey wrote:

Patient is seen in pediatric neurology for following diagnoses:
(1) Chiari malformation which has been surgically decompressed effectively
(2) Migraine headaches
(3) Tics
(4) Autism spectrum disorder-Aspergers type high functioning
(5) Attention deficit disorder

From April 2012 through August 2013, Ms. Caffrey issued a variety of prescriptions for claimant including: “tutoring for math skills-due to autism spectrum disorder”; horseback riding therapy for autism”; “ABA therapy 40 hr/wk”; “social skills group for autism/aspergers”; and “supplies for OT/PT therapy at home.” Some of these prescriptions stated that his need was based on “Aspergers 229.80.”

52. Dr. Sindhu Philip, Psy.D is an ACRC staff psychologist who routinely performs assessments and reviews those performed by her colleagues, for the purpose of determining the existence of developmental disabilities. After reviewing claimant’s records, she testified that she agreed with the ACRC eligibility team that claimant did not meet eligibility criteria for regional center services. She stated that there was no evidence to support a diagnosis of autism.

Dr. Philip testified that Dr. Chez did not complete a “best practices” autism assessment, which would include administration of the ADOS. The tools he used were screening tools used to assist in diagnosis.¹⁴ When concerns are raised, a comprehensive clinical evaluation should

¹⁴ It was also noted that some of the screening tools, including the Connors and

follow. There was no data or explanation how Dr. Chez or his nurse practitioner reached their conclusions and, in fact, the conclusions were inconsistent. Records indicated diagnoses including Autistic Disorder 299.00, Asperger's Disorder 299.80 and "high functioning" autism. There was no discussion of symptoms or indication how claimant might meet the DSM criteria. As a medical doctor, Dr. Chez is qualified to offer medical diagnoses. There was no evidence presented to demonstrate his qualifications to make a clinical autism diagnosis.

Dr. Philip also explained that Dr. Owens did not perform an autism evaluation and only noted Autistic Disorder (per history) based on parent report. Ms. Holcomb's evaluation was specifically for the purpose of determining whether claimant qualified for special education services. Her criteria were based on Education Code requirements and she determined that he did not meet the criteria for "autism" but rather 'autism spectrum.'" Her report specifically stated that it was not intended for use in Lanterman Act eligibility matters. Neither Dr. Owens nor Ms. Holcomb testified at hearing.

In addition, Dr. Philip explained that Dr. Silva performed the only comprehensive "best practice" evaluation of claimant. Her evaluation was thorough and well documented and specifically addressed Lanterman Act eligibility.

Dr. Philip testified that the definition of developmental disability may be different in the Lanterman Act than in other contexts.

53. Dr. Silva also testified and offered an extensive description of claimant's evaluation process which was consistent with what was noted in her report. In discussing parent rating scales she testified that claimant's mother, based on her rating of claimant's adaptive skills, "sees him as someone who functions very low; more typical of someone with more significant disabilities." Dr. Silva did not make the same observations. Dr. Owen also referenced the fact that during his interview with claimant, his communication skills appeared to be better than indicated by the 54 reported by his mother on the VABS-2.

Dr. Silva opined that with ADHD and processing issues, claimant might require more parental support than his older brothers. She found his "atypicalities, which were very noticeable during [their] interaction, to be very typical of ADHD not ASD." She stated that his presentation ruled out autism and was explainable by ADHD.

Eligibility Based on the "Fifth Category" (A Disabling Condition Found to be Closely Related to Intellectual Disability or to Require Treatment Similar to that Required for Individuals with an Intellectual Disability)

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Vanderbilt rating scales, are used in the diagnoses of ADHD.

54. In addressing eligibility under the fifth category, the Court in *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1129, stated in part:

...The fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.

55. Claimant contends that he is qualified to receive services under the fifth category because he either has a condition closely related to intellectual disability, or he requires treatment similar to that required by individuals with intellectual disability.

56. Fifth category eligibility determinations typically begin with an initial consideration of whether claimant had global deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed.

57. A recent appellate decision has suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be largely based on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. The court understood and noted that the Association of Regional Center Agencies had guidelines which recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477). However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Here, claimant believes he requires treatment similar to that required for individuals with mental retardation. He also believes that his condition is closely related to mental retardation.

58. The diagnostic criteria for "Mental Retardation" 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.

59. 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 functioning¹⁵ 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.

¹⁵ 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.”

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

60. 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)¹⁶ 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.

¹⁶ The DSM-V further clarifies that the terms intellectual disability and mental retardation, as well as intellectual developmental disorder, are used interchangeably. The DSM-V contains the following “Note: The diagnostic term *intellectual disability* is the equivalent term for the ICD-11 diagnosis of *intellectual developmental disorders*. Although the term *intellectual disability* is used throughout this manual, both terms are used in the title to clarify relationships with other classification systems. Moreover, a federal statute in the United States (Public Law 111-256, Rosa’s Law) replaces the term *mental retardation* with *intellectual disability*, and research journals use the term *intellectual disability*. Thus, *intellectual disability* is the term in common use by medical, educational, and other professions and by the lay public and advocacy groups.”

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

Specify current severity (see Table 1):

(F70) Mild

(F71) Moderate

(F72) Severe

(F73) Profound [bolding in original]

- 61. 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.

Fifth Category Eligibility-Condition Closely Related to Intellectual Disability

62. Claimant contends that he is eligible for regional center services based upon a condition being closely related to mental retardation due to his impairments in adaptive functioning. The DSM explains that deficits in adaptive functioning can have a number of causes. The fact that claimant has deficits in adaptive functioning alone, is not sufficient to establish that he has a condition closely related to mental retardation. To meet diagnostic criteria for intellectual disability, the DSM-IV-TR requires significantly subaverage general intellectual functioning that is “accompanied by” significant limitations in adaptive functioning. The DSM-V also requires that the deficits in adaptive functioning must be directly related to the intellectual impairments.

63. Claimant’s general intellectual functioning, based on his IQ scores on standardized, intelligence tests, individually administered by Dr. Owens and Ms. Holcomb as set forth above, is in the average to superior range. Ms. Holcomb, in her report, also references earlier testing administered by School Psychologist, Ms. Balcao, which is well within the average range. Claimant did not meet the definition of significantly subaverage intellectual functioning under the DSM, as his scores are well above that range. Thus, claimant does not have this “essential feature” of mental retardation. The fact that claimant may have deficits in adaptive functioning alone, without global intellectual impairment, does not establish that he has a condition closely related to mental retardation.

64. Over the years, claimant has been diagnosed with a variety of conditions, including ADHD, learning disabilities, bilateral hearing loss, headaches and Chiari malformation. Any of these conditions could cause his adaptive functioning difficulties.

65. Terrance Wardinsky M.D., FAAP, is an ACRC Staff Physician and a member of the ACRC Eligibility Team. He testified regarding claimant’s medical conditions.

Dr. Wardinsky testified that Claimant has been diagnosed with Chiari Malformation Type I. He explained that Chiari Malformation is a structural defect of part of the brain, the cerebellum, and the brain stem that is diagnosed when “part of the cerebellum is located below the foramen magnum.” It is classified into various levels from Type 1 (the mildest) to Type 4 (the most severe) and claimant’s Type I is the mildest. Type I is usually asymptomatic. Treatment for Type I is often no treatment. In some cases medications may relieve symptoms and surgery is available to “correct functional disturbances or halt the progression of damage to the central nervous system.” Claimant’s Chiari Malformation was apparently surgically corrected with decompression surgery in 2011. There was no evidence that claimant’s corrected Chiari Malformation constitutes a condition similar to intellectual disability

66. Ms. Holcomb diagnosed claimant with a learning disability and his IEP noted that he qualified for special education services, in part, on the Specific Learning Disability classification. Drs. Silva and Philip testified that the difference between claimant’s IQ scores and his academic achievement/performance might be indicative of a learning disability. A

learning disability does not require significantly subaverage intellectual functioning and was not shown to be closely related to intellectual disability.

There was no evidence presented that claimant qualified for special education as a student with intellectual disability.

67. Claimant does carry a diagnosis of ADHD, and Dr. Philip suggests that claimant's functional deficits could be a consequence of that diagnosis. The DSM-5 describes the functional consequences of ADHD, in part, as follows:

ADHD is associated with reduced school performance and academic attainment, social rejection, and, in adults, poorer occupational performance, attainment, attendance, and higher probability of unemployment as well as elevated interpersonal conflict. Children with ADHD are significantly more likely than their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood . . .

Inadequate or variable self-application to tasks that require sustained effort is often interpreted by others as laziness, irresponsibility, or failure to cooperate. Family relationships may be characterized by discord and negative interactions. Peer relationships are often disrupted by peer rejection, neglect, or teasing of the individual with ADHD. On average, individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers, although there is great variability. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment.

Academic deficits, school-related problems, and peer neglect tend to be most associated with elevated symptoms of inattention, whereas peer rejection and, to a lesser extent, accidental injury are most salient with marked symptoms of hyperactivity or impulsivity.

Claimant was identified as having both inattentive and hyperactive features, rather than either inattentiveness or hyperactivity alone.

68. There was also no evidence that ADHD is closely related to mental retardation. ADHD diagnosis does not require significantly subaverage intellectual functioning. The essential feature of ADHD "is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development."

69. There was no evidence that claimant's medical conditions resulted in a condition closely related to mental retardation.

Fifth Category Eligibility-Condition Requiring Treatment Similar to that Required by Individuals with Intellectual Disability

70. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required by individuals with mental retardation. "Treatment" and "services" do not mean the same thing. Individuals without developmental disabilities may benefit from many of the services and supports provided to regional center consumers. Section 4512, subdivision (b) defines "services and supports" as follows:

"Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of the developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives.

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. But regional center services and supports go beyond treatment, focusing on improving an eligible individual's social, personal, physical or economic status or assisting the individual in living an independent, productive and normal life. Thus, section 4512 elaborates further upon the services and supports listed in a consumer's individual program plan as including "diagnoses, evaluation, *treatment*, personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services..." (Welf. & Inst. Code, § 4512, subd. (b). (Emphasis added). The designation of "treatment" as a separate item is clear indication that it is not merely a synonym for services and supports, and this stands to reason given the broader mission of the Lanterman Act:

It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community. (Welf. & Inst. Code, § 4640.7, subd. (a)).

71. Fifth category eligibility must be based upon an individual requiring "treatment" similar to that required by individuals with mental retardation. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to mental retardation. One would not need to suffer from mental retardation, or any developmental disability, to benefit from the broad array of services and supports provided by ACRC to individuals with mental

retardation. They could be helpful for individuals with other disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, in order to be found eligible.

72. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility both needing “many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training, specialized teaching and skill development approaches, and supported employment services.” (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493.) This broader characterization of “treatment” cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, child care, vocational training, or money management, to qualify under the fifth category without more. For example, such services as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. However, it is unreasonable to conclude that any individual that might benefit from a service or support provided by the regional center, which might also benefit an individual with intellectual disability, requires treatment similar to that required by individuals with intellectual disability. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearing, supra*, 89 Cal.App.4th 1119.) Furthermore the various additional factors required as designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Ca.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the

Mason court determined: “it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of ‘developmental disability’ so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services.” (*Id.* at p. 1129.)

73. The Lanterman Act and Title 17 Regulations do not discuss services and supports available from regional centers in the eligibility criteria. Rather, an individual’s planning team discusses services and supports after that individual is made eligible. Section 4512, subdivision (b) explains:

. . .The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, where appropriate, the consumer’s family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option.

There is no mandate that eligibility determinations include consideration of whether an individual might benefit from an available regional center service or support. Rather, services and supports are determined by the planning team based on “needs and preferences” of the consumer. A need or preference for a specific service or support determined by the planning team is not the same as a determination by a qualified professional of what treatment is required for an individual with a specific developmental disability.

74. For all the above reasons, the treatment needs of claimant will be viewed within the narrower context of those services and supports similar to and targeted at improving or alleviating a developmental disability similar to intellectual disability. The fact that claimant might benefit from some of the services that could be provided by the regional center does not mean that he requires treatment similar to that required by individuals with intellectual.

75. The treatment recommendations made by Dr. Chez and Nurse Practitioner Caffery were based on the belief that claimant had autism/ASD/Asperger’s Disorder and to address Chiari Malformation. Recommendation for a surgical consult resulted in decompression surgery. There were no recommendations based on a condition closely related to intellectual disability and no evidence was presented that these treatments are similar to those required for an individual with intellectual disability.

76. Dr. Owens did not provide treatment recommendations. It is important that he did not indicate any intellectual disability on Axis II of his Diagnosis. He specifically noted that

claimant's abstract thinking, judgment, and ability to understand, remember, and carry out simple and complex instructions is unimpaired.

77. Ms. Holcomb did not provide treatment recommendations similar to that required by individuals with intellectual disability. She stated that claimant's "intellectual ability is best estimated by his very strong verbal skills (WISC-IV Verbal Comprehension SS=126)."

School records did not indicate claimant requires treatment similar to that required by an individual with intellectual disability. There was no evidence that claimant needs treatment similar to that required by an individual with intellectual disability in order to learn.

78. Claimant's mother testified that she must break things down into one-step directions. However, the evidence was clear that this would not be a result of intellectual disability. There was considerable evidence that his ADHD impacted his ability to attend. No evidence was presented that treatment for ADHD or a learning disorder is similar to that required for individuals with intellectual disability.

79. Dr. Philip opined that claimant's deficits in adaptive functioning are better addressed by continued medication and from the treatment perspective of one with ADHD.

80. No persuasive evidence was presented to demonstrate that claimant required treatment similar to that required by an individual with intellectual disability.

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 contends that he exhibits deficits or impairments in his adaptive functioning, is impaired by these limitations, and would benefit from regional center services. However, regional center services are limited to those individuals meeting the stated eligibility criteria. The evidence presented did not prove that claimant has impairments that result from a qualifying condition which originated and constituted a substantial disability before the age of eighteen. There was no evidence to support a finding of intellectual disability or a condition closely related to intellectual disability, or requiring treatment similar to that required for individuals with intellectual disability.

Claimant's behaviors, as described by the witnesses and in the documentary evidence, are indicative of some of the symptoms of autism/autism spectrum disorder. However, those behaviors, even viewed in concert, do not satisfy all of the diagnostic criteria set forth in the DSM-IV-TR. It was not established that claimant has autism, cerebral palsy or epilepsy. Accordingly, he does not have a developmental disability as defined by the Lanterman Act.

3. Claimant bears the burden of establishing that he meets the eligibility requirements for services under the Lanterman Act.¹⁷ He has not met that burden. Therefore, he is not currently eligible for services through ACRC. While claimant does not meet the eligibility criteria for regional center services at this time, if new information becomes available that demonstrates claimant is substantially disabled by a qualifying condition, the new evidence could be provided to ACRC for consideration.

ORDER

Claimant's appeal from the Alta California Regional Center's denial of eligibility for services is denied.

DATED: March 17, 2014

SUSAN H. HOLLINGSHEAD
Administrative Law Judge
Office of Administrative Hearings

¹⁷ 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."

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).)