

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

OAH No. 2012060703

MUSSALLEL F.,

Claimant,

vs.

SAN GABRIEL POMONA REGIONAL  
CENTER,

Service Agency.

**DECISION**

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings, on February 6, 2013, in Pomona, California. San Gabriel Pomona Regional Center (Service Agency or SGPRC) was represented by its Fair Hearing Manager, G. Daniela Martinez. Mussallel F. (claimant) was represented by his court-appointed guardian and authorized representative, Evelyn H.<sup>1</sup>

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on February 6, 2013.

**ISSUE**

Should Claimant remain eligible to receive regional center services? (i.e. Was the prior determination by SGPRC that Claimant was eligible to receive regional center services clearly erroneous?)

---

<sup>1</sup> Claimant's and his guardian's initials are used, in lieu of their last name, in order to protect their privacy.

## FACTUAL FINDINGS

1. Claimant is a 13-year-old (born 2/20/99) male client of the Service Agency. Prior to 2002, he received regional center services through the Early Start Program.<sup>2</sup> In 2002, just prior to his third birthday, he was found eligible for regional center services due to diagnoses of Mild Mental Retardation and “very mild” Cerebral Palsy. (Exhibit 1.)

2(a). The diagnosis of Mild Mental Retardation was based on a psychological evaluation by Frank J. Trankina, Ph.D., conducted on December 19, 2001, when Claimant was two years, nine months old. At that time, Dr. Trankina interviewed Claimant’s grandmother, and she reported “a history of significant mental health problems in the biological parental background.” (Exhibit 2.)

2(b). Dr. Trankina noted:

[Claimant] was referred to provide updated determination of level of functioning for eligibility review purposes and program planning. [Claimant] has been participating in programs in the early intervention unit. He demonstrated early delays in most areas of development. He began walking at about 15 months. When he was about 2 years, 1 month, vocabulary was of ten words only. [Claimant] also received a diagnosis of mild cerebral palsy, though [he] is doing quite well now along these lines and does not demonstrate any type of paralysis or muscle problem.

(Exhibit 2.)

2(c). Dr. Trankina administered the Peabody Picture Vocabulary Test (Peabody), the Mecham Verbal Language Development Scale (Mecham), the Beery Developmental Test of Visual Motor Integration (Beery), the Stanford-Binet Intelligence Scale, Fourth Edition and Form L-M, and the Vineland Adaptive Behavior Scales (Vineland). In his interpretation of Claimant’s test results, Dr. Trankina stated:

**Communication:** On the Peabody, a measure of receptive word knowledge, [Claimant] placed at age level of 1 year, 9 months. This test requires child to choose and point to pictures that are verbally named. The Mecham is completed by child observation and family report and includes expressive items as well. [Claimant] placed at age level 1 year, 2 months. Vocabulary is reported to be under 25 words,

---

<sup>2</sup> “Early Start” is the name used in California to refer to a federal program for young children (under 36 months) at risk for certain disabilities. The governing law for Early Start is The Individuals with Disabilities Education Act (IDEA), Subchapter III, Infants and Toddlers with Disabilities (20 U.S.C. , §§ 1431-1445) and the applicable federal regulations found in Title 34, Code of Federal Regulations, section 303, et seq.

and [Claimant] is not speaking in short sentences. He is able to recognize only a few body parts. He is not able to say his name. He is not using pronouns. He is not able to name any colors. He is not able to verbalize toilet needs.

**Psychomotor Functioning:** [Claimant] was not able to complete any of the basic designs on the Beery on his own. He was able to imitate one basic design, placing at age level of 1 year, 9 months for visual motor integration. Gross motor functioning, as indicated by the results on the Vineland, is at 1 year, 8 months. [Claimant] is able to go up and down stairs, putting both feet on each step. He is beginning to run, but cannot do so with good coordination and falls easily. He is not able to jump over small object[s]. He is not able to pedal a tricycle.

**Intellectual Functioning:** The Stanford-Binet Intelligence Scale, 4th edition, was administered and [Claimant] was able to give some response. However, as is often the case for the delayed child, a valid basal level could not be established on this instrument. Basal level is the level at which child can pass all items, and different instruments have varying basal levels. The Stanford-Binet Intelligence Scale, Form L-M, was also administered. This test continues to be viewed as valid and meaningful for the young child for whom there is a probable delay. [Claimant] passed all items at the 2 year old level, which was the basal level. He received one month credit at the 2 ½ year old level. No items were passed beyond that level. The resulting mental age score is 2 years, 1 month. This yields an IQ score of 65, using the newer norms of this edition of the test. The result is in the range of mild developmental delay.

**Adaptive Functioning:** . . . Daily living skills are at 1 year, 6 months; socialization is at the 10 month level.

[Claimant] primarily uses fingers for eating, though he is beginning to learn to use a spoon, though not a fork. He is able to drink from a cup on his own. He does not seem to understand that hot things are dangerous. He is not potty trained and he does not indicate when wet or soiled. He is fully dependent for bathing and dressing. He is able to put possessions away when asked to do so.

[Claimant] is able to participate in activities with others at very basic level only. He generally does not imitate simple adult movements such as waving goodbye. He can demonstrate some interest in the activities of others. He does not engage in elaborate imaginative play activities. There are times when he can be rather active. This could include his being impulsive, with aggressive behaviors. (Exhibit 2.)

2(d). Dr. Trankina's diagnostic impressions were:

Intellectual Functioning: mild mental retardation

Adaptive Functioning: in the mild range

Substantially Handicapping Conditions: learning, communication, self-care, self-direction

(Exhibit 2.)

3(a). Thereafter, the Service Agency received records from Claimant's school district, including a Multidisciplinary Team Report, dated September 16, 2009. (Exhibit 3.)

3(b). The Multidisciplinary Team Report noted:

[Claimant] is a fifth grade student . . . . He was referred for a triennial evaluation to determine continued eligibility and need for Special Education services. According to a review of records, IEP dated 12-5-2008, [Claimant] is eligible for Special Educational services under the primary category of Language/Speech Disorder. Specifically, in the areas of articulation, reduced intelligibility, morphology, syntax, and semantics. The 12-5-2008 IEP also indicates that he is eligible under the secondary category of Other Health Impaired (OHI) due to Attention Deficit – Hyperactivity Disorder [(ADHD)]. He is currently receiving services through the Special Day Class program (SDC).

(Exhibit 3.)

3(c). As part of the evaluation, the Claimant's grandmother and legal guardian, Evelyn H., was interviewed regarding his developmental history. The report noted that Claimant's biological mother engaged in poly-substance drug abuse while pregnant with Claimant and that he was diagnosed with developmental delays.

3(d). The report further noted that, in 2002, Claimant attended an SDC for pre-kindergarten, but that on October 10, 2003, his SDC was discontinued, although "he continued to qualify for Special Education services under Speech and Language." (Exhibit 3.) He was placed in pre-school on October 27, 2003, but "due to behavioral challenges, and an IEP review, he was moved to the Emotional/Behavioral Disturbance [(ED/BD)] program in Pre-Kindergarten . . . beginning 6-14/2004." (Exhibit 3.) He remained in the ED/BD program, and in 2006, was mainstreamed into a general education classroom. Nevertheless, due to behavioral challenges, he was placed on a modified school day of three hours per day, and in the Fall of 2007, he was again placed in a SDC-ED/BD setting. In November 2007, Claimant began receiving speech therapy services through his school district.

3(e). The report documented teachers' (general education and special education) observations of Claimant's behavioral problems, including throwing items, ripping materials from the walls, defiance, aggressiveness, leaving the classroom without permission, and biting a teacher on her arms. On September 14, 2009, Claimant was suspended from school "for disrupting the class, defiance, and fighting. His disciplinary record indicates that he attacked the teacher, scratched her, pulling her arm and yelling. Once in the main office, he continued to yell, kick, and threw the phone on the floor." (Exhibit 3.)

3(f). Prior evaluations were reviewed by the team, including Dr. Trankina's report. Additionally, the following assessments were noted:

The Initial Pre-School Assessment, 2-4-2003, conducted by Mary E. Haggard, School Psychologist, indicated that [Claimant] possessed cognitive delays. However, a case review dated 9-23-2003 was done to clarify his diagnosis and to determine the appropriate placement for him. These assessment findings stated that [Claimant's] cognitive abilities, academic and adaptive functioning fell in the low average to average range. Thus, he did not meet the eligibility criteria of mild mental retardation. His classification was changed from Mental Retardation to Speech and Language impaired, with difficulties in receptive and expressive language.

The 9-6-2006 assessment conducted by Kristain Gonzalez, School Psychologist . . . estimate his cognitive abilities are within the average range. His academic skills were assessed to be within the average to high average range. His adaptive functioning is estimate to be within the low average to average range. Lastly, his social/emotional functioning was found to be within normal limits.

(Exhibit 3.)

3(g). The team conducted an assessment of Claimant's intellectual functioning, and he obtained a score of 87, which was in the low average range. The team also conducted an assessment of Claimant's academic functioning and found that his "estimated cognitive abilities are commensurate with his overall academic abilities in the areas of reading, writing and math." (Exhibit 3.) A social-emotional assessment revealed areas with a "high level of maladjustment" and additional testing revealed that "an ADHD classification is strongly indicated. [Claimant] also shows characteristics consistent with conduct disorder, oppositional defiant disorder and serious emotional disturbance." (Exhibit 3.)

3(h). The team summarized its findings as follows:

[C]urrent assessment results estimate his cognitive ability to be within the low average range. His academic performance in overall reading is

within the low average range, overall math is within the average range, while his overall writing abilities are also estimated to be within the average range. His social/emotional/behavioral standardized and non-standardized measures continue to reflect challenging behaviors that seem consistent with his ADHD diagnosis as well as meeting the eligibility criteria of a Severe Emotional Disturbance. Thus, he continues to qualify for special educational services under the primary eligibility category of Emotional Disturbance and secondarily under the category of Other Health Impaired (OHI).

(Exhibit 3.)

4. Claimant has been receiving school-based and outside counseling services for several years, and is currently receiving counseling services through ENKI Youth and Family Services. (Exhibit 3; Testimony of Evelyn H.)

5. Given the school district's findings that claimant's cognitive abilities were in the low average range, the Service Agency referred claimant for a psychological evaluation.

6(a). On May 17, 2011, Pean Lai, Ph D., conducted a psychological assessment of Claimant. The assessment included a review of Claimant's history records, an interview with Claimant's grandmother, observations of Claimant, and administration of diagnostic tools for measuring cognitive functioning and adaptive skills. (Exhibit 4.)

6(b). Claimant's grandmother stated that she was concerned that Claimant's communication skills continue to be poor and that it is difficult to understand his speech. Dr. Lai observed:

[Claimant] communicated clearly, using English. He sometimes had difficulties with verbal comprehension, asking questions to be repeated. His speech was easily understood. He was oriented to time, place and person. . . . [His] handwriting was clear and legible. He was able to read at least in the fourth grade level. However, he struggled with more complex words.

(Exhibit 5.)

6(c). To assess Claimant's cognitive functioning, Dr. Lai administered the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV). Claimant obtained a Full Scale IQ Score of 78. However, Dr. Lai noted:

This score is not representative of his overall abilities, due to a significant discrepancy of over one standard deviation found between his verbal and nonverbal abilities.

His Verbal Comprehension IQ score of 69 falls in the extremely low classification. [Claimant's] verbal abilities are in the borderline to extremely low classification. He has relative strength for tasks that require distinction between nonessential and essential features and verbal expression. His relative weakness is found on tasks that require verbal learning ability and fund of knowledge. His Working Memory abilities fell solidly in the low average classification [with a score of 86].

His Perceptual Reasoning score of 86 falls in the low average classification. . . . [His] Processing Speed abilities fell in the average classification [with a score of 97].

(Exhibit 4.)

6(d). To assess claimant's adaptive functioning, Dr. Lai administered the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II). Claimant's Vineland-II Composite score (74) placed him in the moderately low range of adaptive functioning. In the Communication domain (standard score 75), Daily Living Skills domain (standard score 78), and Socialization domain (standard score 75), Claimant's adaptive functioning was in the moderately low range. (Exhibit 4.)

6(e). Based on her assessment, Dr. Lai's diagnostic impressions were: "Rule Out Language Disorder, NOS" and ADHD "per report." She did not diagnose him with Mental Retardation. Dr. Lai opined:

[Claimant's] cognitive abilities do not reflect [a] diagnosis of mental retardation. Instead, his IQ scores are suggestive of learning disorder, given [the] significant discrepancy between [his] verbal and nonverbal abilities. His verbal abilities require significant attention, as they fall in the extremely low classification. On the contrary, his nonverbal abilities are in the average classification. His adaptive skills are in the moderately low range of functioning.

(Exhibit 4.)

6(f). Dr. Lai recommended that Claimant receive intensive speech/language therapy to improve his verbal comprehension. (Exhibit 4.)

7(a). On March 21, 2012, Larry Yin, M.D., Medical Consultant for SGPRC, conducted an assessment of Claimant to clarify his medical diagnoses including the level of severity of his cerebral palsy. Review of Claimant's medical records revealed:

[O]n February 11, 2000, [Claimant was seen] for evaluation at San Francisco General Hospital, Children's Health Center to see Dr. Weiss, a child neurologist. . . . [Claimant] was found to have increased muscle

tone on the left side with increased hip tone, decreased truncal tone and cross adductor reflex bilaterally. At that time he was diagnosed with “mild spastic quadriplegia, gross developmental delay and history of poly-substance drug exposure with evolving hypertonia.

(Exhibit 5.)

7(b). Dr. Yin noted that Claimant had “no difficulty with ambulation, [and was] independent in all areas of daily living.” (Exhibit 5.)

7(c). Dr. Yin’s impression, after physical examination, was:

[C]erebral Palsy was diagnosed at 12 months old by Dr. Weiss. [Claimant] has done well with his gross and fine motor skills. His physical exam did not demonstrate abnormal muscle tone in the trunk or extremities. His muscle strength was normal as was his gait and fine motor skills. The rest of the exam was essentially unremarkable. Although he was diagnosed at 12 months with cerebral palsy, his exam today is no longer consistent with mild spastic quadriplegic cerebral palsy. He has full range of motion about all joints and extremities, his muscle tone is normal, his gait and coordination is [*sic*] normal for age and he speaks clearly without dysarthria. Based on the exam, I would not consider [Claimant’s] previous diagnosis of Cerebral Palsy to be substantially handicapping and did not find existing evidence of cerebral palsy.

(Exhibit 5.)

8. On May 23, 2012, the SGPRC eligibility team held an interdisciplinary team conference to review claimant’s file for an eligibility determination. Based on his low average cognitive abilities (and therefore his failure to meet the criteria for a qualifying diagnosis of mental retardation) and on his lack of substantial disability from cerebral palsy, the team found claimant ineligible to continue receiving regional center services. (Exhibit 6.)

9. On May 29, 2012, the Service Agency sent Claimant a Notice of Termination of Eligibility, stating that “the eligibility team decided that the original decision that made [Claimant] eligible for Regional Center services is clearly erroneous” because Claimant “does not have mental retardation” and “is not substantially disabled as a result of Cerebral Palsy.” (Exhibit 7.)

10. Claimant’s grandmother filed a Fair Hearing Request and this matter ensued. (Exhibit 8.)

11(a). At the fair hearing, Claimant’s grandmother testified credibly on his behalf and submitted additional documents from Claimant’s school district. These documents

included a Speech/Language Assessment Report dated September 1, 2012, which noted that, based on the assessment, Claimant “meets the eligibility criteria for placement in the Language and Speech (LSS) program.” (Exhibit C.)

11(b). The documents submitted by Claimant also included a Triennial Psycho-Educational Team Assessment dated September 7, 2012, which noted that Claimant’s learning potential, psychological processes, and academic functioning were all in the low average range. However, he had a history of significant social/emotional and behavioral difficulties which adversely affected his educational performance. Consequently, the evaluation team determined that Claimant continued to meet the eligibility criteria for special education services under the categories of “Emotionally Disturbed” and “Other Health Impaired.” (Exhibit D.)

12. Claimant’s grandmother acknowledged that, if Claimant does not have mild mental retardation, she “can accept that.” However, she believes that Claimant is “developmentally delayed and can benefit from regional center services.” He was previously provided respite care and behavioral intervention through the regional center. She noted that she will soon be 61 years old and wants to ensure that Claimant continues receiving necessary services. (Testimony of Evelyn H.)

13. The evidence established that Claimant does not suffer from Mental Retardation.

14. The evidence established that Claimant is not substantially disabled as a result of Cerebral Palsy.

15. The earlier determination of Claimant’s eligibility in 2001, upon reevaluation, has proven to be clearly erroneous.

## LEGAL CONCLUSIONS

1. Claimant does not suffer from a developmental disability entitling him to regional center services. (Factual Findings 1 through 15; Legal Conclusions 2 through 12.)

2. Where a change in the status quo is sought, the party seeking the change has the burden of proving that a change is necessary. (Evid. Code, §§ 115 and 500.) In 2001, the Service Agency originally determined that Claimant was eligible for regional center services. The Service Agency now seeks to change its determination of eligibility, arguing that its original determination was clearly erroneous. Since the Service Agency is the party seeking a change in eligibility, it bears the burden of proof. The Service Agency has met its burden.

3. Welfare and Institutions Code section 4643.5, subdivision (b), provides:

An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

4. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512 defines “developmental disability” as:

a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

5(a). To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a “substantial disability.”

5(b). California Code of Regulations, title 17, section 54001 states, in pertinent part:

(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 significant functional limitations, 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:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

5(c). In California Code of Regulations, title 17, section 54002, the term “cognitive” is defined as:

the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.

6(a). In addition to proving a “substantial disability,” a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as “Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512.) This category is not further defined by statute or regulation.

6(b). Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

6(c). While the Legislature did not define the fifth category, it did require that the qualifying condition be “closely related” (Welf. & Inst. Code, § 4512) or “similar” (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or “require treatment similar to that required for mentally retarded individuals.” (Welf. & Inst. Code, § 4512.) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be “closely related” or “similar” to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual’s disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant’s cognitive and adaptive functioning and a determination of whether the effect on his/her performance renders him/her like a person with mental retardation. Furthermore, determining whether a claimant’s condition “requires treatment similar to that required for mentally retarded individuals” is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone’s condition *requires* such treatment.

7. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination), and who does *not* have a developmental disability would not be eligible.

8(a). The Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision 2000) (DSM-IV-TR), describes mental retardation as follows:

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning 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 (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). 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 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. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ,

will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards 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. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute. (DSM-IV-TR, pages 39 - 42.)

8(b). The DSM-IV-TR describes persons with Mild Mental Retardation (I.Q. level of 50-55 to approximately 70) as follows:

typically develop social and communication skills during the preschool 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 settings. (DSM-IV-TR, pages 42 - 43.)

9(a). In this case, the evidence established that claimant does not currently meet the DSM-IV-TR criteria for a diagnosis of Mental Retardation or Mild Mental Retardation.

9(b). The evidence did not establish that claimant suffers from a “disabling condition found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals.”

10. Additionally, the evidence established that Claimant is not substantially disabled as a result of Cerebral Palsy.

