

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

KEISHAWN J.,

Claimant,

vs.

NORTH LOS ANGELES COUNTY  
REGIONAL CENTER,

Service Agency.

OAH No. 2012100688

DECISION

Administrative Law Judge Michael A. Scarlett, Office of Administrative Hearings, State of California, heard this matter on February 11, 2013, in Lancaster, California. Rhonda Campbell, Contract Officer, represented North Los Angeles County Regional Center (Service Agency or NLACRC). Jacqueline E. (Mother) was present and represented Janelle J. (Claimant).<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 11, 2013.

ISSUE

Does Claimant have a developmental disability entitling her to eligibility for regional center services?

---

<sup>1</sup> Claimant's last initials are used in this Decision, in lieu of her surname, in order to protect her privacy.

## FACTUAL FINDINGS

1. Claimant is a nine year-old boy who currently resides with his mother, age 31, and five siblings, two sisters 14 and 5 years old, and three brothers, ages 10 and 11 years old, and 23 months. Mother seeks regional center eligibility for Claimant based upon mental retardation and/or autism. Claimant and the 5 and 10 year-old siblings have the same father, who is currently incarcerated serving a five-year sentence for a domestic violence conviction for conduct against Mother. Mother and the four younger children lived in a shelter for a period of time because of this father's domestic violence. Claimant's older two siblings have the same father, and until recently were living with a maternal grandmother. The 23 month old sibling also has a different father. Mother had no information about any of the fathers' family or medical history. Claimant is currently attending third grade in the Lancaster School District. The school district conducted Claimant's first Individualized Education Program (IEP) on February 7, 2013.

2. On August 13, 2012, Service Agency determined that Claimant was not eligible for regional center services. Service Agency based its determination upon a social assessment dated May 7, 2012, prepared by Viktoria Penchuk, M.A. (Penchuk), an Intake Vendor for the Service Agency; a June 5, 2012, medical summary prepared by Carlo De Antonio, M.D., FAAP; a July 12, 2012, psychological evaluation prepared by Ann Walker, Ph.D.; a December 23, 2010, Child & Family Guidance Center (CFGC) Adolescent Initial Assessment; a December 23, 2010, Cognitive Screening Test performed by Linda C. Gilbert, Ph.D.; and March 30, 2011, Child & Family Guidance Center Progress Notes prepared by Dr. Clinton Y. Montgomery, M.D. Mother provided no independent assessments or evaluations in support of Claimant's application for regional center services.

3. The Service Agency denied services to Claimant and issued a Notice of Proposed Action (NOPA) on August 13, 2012. On October 11, 2012, Claimant submitted a request for fair hearing. Although the fair hearing request was submitted outside the 30-day time period to file an appeal of the Service Agency's denial of eligibility, Service Agency did not object that the fair hearing request was untimely. On November 7, 2012, Service Agency proceeded to an informal meeting with Claimant, and deferred an "informal decision" on Claimant's appeal pending a school observation by a regional center psychologist. On January 31, 2013, after a school observation was conducted by Sandi J. Fisher, Ph.D., Service Agency again advised Claimant that he was not eligible for regional center services and that if he was not in agreement with the ineligibility determination, Claimant should proceed to fair hearing. All jurisdictional requirements have been satisfied to proceed to hearing.

4. On December 23, 2010, CFGC performed an Adolescent Initial Assessment for mental health services for Claimant. The assessment noted that Claimant had difficulty following instructions, staying seated in class, breaking things when he became angry, being easily angered, impulsive, short attention, and sibling fighting. At that time, Mother believed Claimant's behaviors were a result of his exposure to the father's domestic violence against Mother. Mother informed the assessor that Claimant's behavior problems occurred primarily

at school, that he fought with his peers at school, and became angry and aggressive if accidentally touched by another child. Mother also told CFGC assessor that she believed Claimant had Attention Deficit Hyperactivity Disorder (ADHD). The assessor noted that Claimant appeared happy and looked his age, but that he could not sit still during the assessment. The assessment concluded that Claimant was moderately impulsive and had difficulty paying attention and the assessor diagnosed him with ADHD. Behavioral therapy was recommended for both Mother and Claimant.

5. On December 23, 2010, Claimant was administered a Cognitive Functioning Screening by Linda C. Gilbert, Ph.D. in connection with the CFGC Adolescent Initial Assessment. Dr. Gilbert observed that Claimant was polite and cooperative, but that it was difficult for him to be still during his intake session. She administered the Beck Youth Inventories, 2nd Edition (Beck2) and the Kaufman Brief Intelligence Test, 2<sup>nd</sup> Edition (K-BIT2), but noted that Claimant's hyperactivity affected his ability to respond to the tests. Dr. Gilbert concluded that Claimant was "clearly an ADHD child" with "below average to average range" intellectual functioning. She opined that if his hyperactivity could be successfully treated, "his behavioral and academic difficulties are likely to improve."

6. On May 7, 2012, Service Agency conducted a social assessment of Claimant in conjunction with his application for regional center services. Claimant's Mother and two siblings ages 10 and 5, were present during the social assessment. Mother was the main source of information for the social assessment. Claimant was born full term without complication and Mother received prenatal care. Claimant started walking at 12 months-old, spoke his first words at two years-old and began speaking in sentences at age three. Mother stated that during his first three years, Claimant appeared to be achieving his developmental milestones in a timely manner. Claimant is fully ambulatory and has no motor limitations or restrictions. During the assessment, Claimant did not initiate any contact or communication with his siblings, although he was responsive to the assessor and complied with the interview portion of the assessment. He ignored his sister's attempts to engage him in play and failed to even acknowledge her presence in the room. Claimant was observed being interested in puzzles, but was not able to complete any of the puzzles available in the room. He also played with hand puppets for a while. Claimant is able to dress himself independently, can perform most of his personal hygiene tasks independently without reminders, and can feed himself using utensils.

7. Claimant responded to his name when called during the social assessment, answered questions appropriately and was able to maintain communication. His speech was clear and well-understood. Claimant was observed to have poor eye contact in a group of people, but in one-on-one interaction he made better eye contact. Mother reported no concerns regarding Claimant's interaction and play with other children. He was observed playing with a few toys in a "meaningful way" (creating a scenario and talking on behalf of his story persons) during the assessment. Mother reported that Claimant recognizes social cues appropriately and shares enjoyment and interest with others. Mother reported no head banging, leaning from side, rocking or running/spinning in circles, and the assessor observed no repetitive behaviors or body mannerisms during the assessment. Mother reported that

Claimant has a common sense of safety awareness, does not require constant supervision, and does not display self-injurious or wandering behaviors. Claimant is disruptive at school and presents with aggressive behaviors.

8. On March 30, 2011, Dr. Clinton Y. Montgomery, M.D., performed a “psychiatric evaluation” of Claimant, from which his “progress notes” were made available to the Service Agency. Dr. Montgomery diagnosed Claimant with ADHD. He also noted that Claimant suffers from Bronchitis, but that he was otherwise in good health.

9. On June 5, 2012, Dr. Carlo De Antonio, M.D. reviewed the available medical records pertaining to Claimant. Dr. De Antonio’s medical summary concluded that there is no basis for a diagnosis of cerebral palsy, epilepsy, or major medical condition. He noted Claimant’s diagnosis of ADHD and that Claimant was taking Tenex. Claimant offered no medical evidence to the contrary to support a diagnosis of cerebral palsy or epilepsy.

10. On July 12, 2012, Dr. Walker performed a psychological evaluation on Claimant for purposes of an eligibility determination for regional center services. Dr. Walker administered the Wechsler Intelligence Scale for Children – 4th Edition (WISC-IV), the Wide Range Achievement Test – 4th Edition (WRAT-4), the Autism Diagnostic Observational Schedule, Module 3 (ADOS, Module 3), the Autism Diagnostic Interview-Revised (ADI-R), the Gilliam Autism Rating Scale-2<sup>nd</sup> Edition (GARS-2), and the Vineland Adaptive Behavior Scales-2<sup>nd</sup> Edition (Vineland II). She also conducted a clinical interview, reviewed Dr. De Antonio’s medical summary, and reviewed records provided by the Service Agency.

11. Claimant separately easily from his family when taken by the examiner to a separate test room for the psychological evaluation. Per the observations of the examiner, Claimant was highly impulsive, easily distracted, and showed an attention span of about two minutes and never sat still during the evaluation. Claimant responded very well to encouragement, showed good effort during the testing, and was easily redirected when he was distracted. Mother completed the GARS-2 independently and was interviewed to complete the ADI-R. Mother was noted to be an honest and accurate informant by the examiner. The testing was completed in one hour and 30 minutes.

12. On the WISC-IV, Claimant’s visual reasoning, immediate verbal memory, and speed in timed visual motor coordination tasks were in the normal range. He showed significant weakness in his abstract verbal reasoning (significantly below average), but in all other areas of cognitive functioning he scored in the normal range (Verbal Comprehension 79, borderline range; Perceptual Reasoning 86, low average range; Working Memory 102, average range; Processing Speed 85, low average range.) Claimant’s Subtest Scale Scores were as follows: Similarities: 5 (low range); Vocabulary: 10 (average range); Comprehension: 11 (average range); Block Design: 8 (average range); Picture Concepts: 8 (average range); Matrix Reasoning 7 (average range); Digit span: 11 (average range); Letter Number Sequencing: 10 (average range); Coding: 8 (average range); and Symbol Search: 7 (low average range). A full Intelligence Quotient (IQ) was not considered because of the 23-

point difference in Claimant's highest and lowest scores. Claimant's scores on the WRAT-4, for academic performance were below grade level and not consistent with his level of intelligence. His scores were Math Computation: scaled score 83 (grade level 1.7) and Word Reading: scaled score 67 (grade level K-2).

13. Administration of the Vineland II rendered borderline range scores for communication and daily living skills and low average or normal range scores for social skills. Claimant's domain standard scores were Communication 77 (low or borderline range); Daily Living 73 (low or borderline range); and Socialization 87 (low average range). The examiner noted that Claimant could engage in conversations, knew letters of the alphabets and could read simple words. He was able to bath and dress independently, help with some chores, and understood that things like knives were dangerous. Claimant has many different friends at school and enjoys playing sports, but had poor control of his anger.

14. The ADOS, Module 3 and the ADI-R indicated that Claimant's scores were below the autism-spectrum and autism cut-offs. The ADOS, Module 3 yielded a total communication and reciprocal social interaction score of "6", with the autism cut-off being 10, and the autism-spectrum cut-off being 7. The examiner noted that stereotypic use of words was not observed, that Claimant was able to report events without probes and was able to both describe routine and non-routine events. He engaged in conversations, showed appropriate gestures, and used eye contact and facial expression to modulate social interaction. Per the examiner, Claimant's social overtures were limited to his areas of interest and social response was limited, noting that rapport was aloof at times, and friendly and cooperative at other times. Claimant showed reciprocal social communication, talked about his feelings, friends, and his anger when his little sister touches his things.

15. The ADI-R scores were below the autism cut-off. Mother's interview yielded a score of "2" for abnormalities in reciprocal social interaction, with the autism cut-off being 10, a score of "2" for abnormalities in communication, with the autism cut-off being 8, and "0" for restricted and stereotyped patterns of interests, with the autism cut-off being 3. Mother reported that Claimant uses eye contact to engage in social interaction but typically avoids eye contact with his Mother if he is angry with Mother. Mother also reported that Claimant is developing appropriate peer relationships. He initiates interaction and shows cooperative play skills that are appropriate for his age level. He is able to share interest and enjoyment and show emotional reciprocity, but he has not fully developed emotional reciprocity. Claimant does not comfort others, and sometimes appears to be in his own world. Mother reported that Claimant was slow start talking and that she observed jargonizing and echolalia in his speech, but the examiner did not observe this. There were no restricted areas of interests reported, with Mother stating he likes playing football, basketball, and video games and likes to ride his bike. Mother reported no compulsive adherence to nonfunctional routine, no repetitive motor mannerisms, no unusual sensory sensitivity, or preoccupation with parts of objects. She did note that Claimant was "always moving around."

16. On the GARS-2, which Mother completed independently, Claimant's Autism Index score was 72 or three percent, including subscale standard scores of "3" for stereotypic behavior, "9" for communication skills, and "5" for social interaction skills. Mother stated that Claimant sometimes screams for self-stimulation and sometimes hits himself. She also stated that Claimant repeats words and uses gestures instead of words to indicate what he wants, and has frequent temper tantrums.

17. Dr. Walker concluded that Claimant did not meet the criteria for mental retardation based upon Claimant's WISC-IV, WRAT-4, and the Vineland II tests scores. Claimant performed in the low average to average range (normal range) in all areas of intelligence except verbal abstract reasoning, in which a significant weakness was recorded (borderline range). Based upon the ADOS, Module 2, the ADI-R, and the GARS-2, Dr. Walker concluded that Claimant did not meet any of the criteria for a diagnosis of autism under the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, 4th Edition, Text Revision (DSM-IV-TR).

18. Dr. Walker diagnosed Claimant with Attention Deficit-Hyperactivity Disorder (ADHD), combined type, Oppositional Defiant Disorder (ODD), and Learning Disorder NOS (noting a weakness in abstract verbal reasoning). She recommended that Claimant continue counseling and psychiatric care at CFGC for his ADHD and ODD, and that Mother consider parenting skills training followed by behavioral therapy to address Claimant's expressions of anger at home. Finally, Dr. Walker stated that Claimant should be referred for an appropriate school placement, with Special Education support likely and a mental health assessment considered. She concluded that Claimant was not performing at an academic level consistent with his intelligence because of the ADHD and Learning Disability.

19. On February 7, 2013, Claimant received his initial IEP from Lancaster School District. This IEP was not available to Service Agency at the time the eligibility determination was made. Claimant was found to be eligible for Special Education services based upon a Learning Disability. Administration in of the Woodcock Johnson III yielded "very low" standard scores across all areas tested. The Motor-Free Visual Perception Test (MFVPT-3) and the Cognitive Assessment System (CAS) was administered and indicated that Claimant "most likely has average cognitive ability or learning potential with significant strengths in visual processing." Significant deficits in attention were noted, despite Claimant's medication for ADHD, and were suspected of impeding Claimant's performance on the CAS, MFVPT-3, and the Test of Auditory Processing Skills (TAPS-3).

## LEGAL CONCLUSIONS

1. Claimant has not established that he suffers from a developmental disability entitling him to regional center services. (Factual Findings 1 through 19.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is

referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his or her eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met his burden of proof in this case.

3. In order to be eligible for regional center services, a Claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512, subdivision (a),<sup>2</sup> defines "developmental disability" as:

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 mental retardation, cerebral palsy, epilepsy, and 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.

4. To prove the existence of a developmental disability within the meaning of section 4512, an individual must have a "substantial disability." Section 4512, subdivision (1), defines "substantial disability" as the existence of significant functional limitations in three or more of the following areas of major life activity: (1) self-care, receptive and expressive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, and (7) economic self-sufficiency. California Code of Regulations, title 17, section 54001, subdivision (a), provides that:

(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;

---

<sup>2</sup> All further references are to the Welfare and Institutions Code unless otherwise indicated.

- (B) Learning;
- (C) Self-care;
- (D) Mobility;
- (E) Self-direction;
- (F) Capacity for independent living;
- (G) Economic self-sufficiency.

5. Claimant must show that his “substantial disability” fits into one of the five categories of eligibility in section 4512. These categories are mental retardation, epilepsy, autism and cerebral palsy, and a fifth category of eligibility described as having “disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (§ 4512, subd. (a); Cal. Code. Regs., tit. 17, § 54000.) Under the Lanterman Act, “developmental disability” excludes conditions that are *solely* physical in nature. (§ 4512; Cal. Code. Regs., tit. 17, § 54000.) Section 54000, subdivision (c), excludes conditions that are *solely* psychiatric disorders, learning disabilities, or physical in nature.

#### *Autistic Disorder*

6. The evidence did not establish that Claimant has an Autistic Disorder. The DSM-IV-TR states that “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.” The DSM-IV-TR describes the diagnostic criteria for autism to include the following:

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
  - (1) qualitative impairment in social interaction, as manifested by at least two of the following:
    - (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
    - (b) failure to develop peer relationships appropriate to developmental level
    - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
    - (d) lack of social or emotional reciprocity
  - (2) qualitative impairments in communication as manifested by at least one of the following:

- (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
  - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
  - (c) stereotyped and repetitive use of language or idiosyncratic language
  - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
- (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
- (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
  - (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
  - (d) persistent preoccupation with parts of objects
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

(DSM-IV-TR at pp. 70-71, and 75.)

7. During Claimant's May 7, 2012, social assessment, although he did not communicate with his siblings, Claimant responded to his name, was responsive to the examiner when questioned, and complied with the interview portion of the assessment with clear and well understood speech. Claimant had poor eye contact in a group setting but made better eye contact in one on one interaction. Although Claimant did not interact or play with his siblings during assessment, Mother reported no concerns regarding play skills or interactions with other children, except that he angered very easily and would often fight with his siblings and school friends. Claimant showed interests in puzzles and played with a few toys during the evaluation. Dr. Walker administered the ADOS, Module 2 and the ADI-R tests during the July 12, 2012, psychological evaluation. Claimant's scores on these two tests were below the Autism Disorder and Autism-Spectrum cut-offs. Consistent with observations during his social assessment, Dr. Walker indicated that Claimant was highly impulsive and easily distracted with a very short attention span. He was never still during the evaluation and responded in a highly impulsive manner to test materials. However, when encouraged by the examiner he responded very well

and seemed to want to put forth his best effort. Claimant engaged in conversations with the examiner and no stereotyped use of words was observed. He made eye contact and used facial expressions when interacting socially. Claimant's social overtures and responses were limited, primarily around his interests in sports and information about his school friends, but he did show some reciprocal social communication in these areas. Mother reported no restricted areas of interests, compulsive adherence to routine, repetitive motor mannerisms, unusual sensory sensitivity, or preoccupation with parts of objects, and none were observed by the examiner. Dr. Walker concluded that Claimant had not met any of the criteria required for a diagnosis of autism under the DSM-IV-TR. Claimant presented insufficient evidence to the contrary. Accordingly, Claimant failed to establish that he is entitled to regional center eligibility based upon a diagnosis of Autism.

### *Mental Retardation*

8. The DSM-IV-TR defines 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—3rd Edition, Stanford-Binet, 4th Edition, 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 at pp. 39 - 42.)

9. Regarding Mild Mental Retardation (I.Q. level of 50-55 to approximately 70), the DSM-IV-TR states:

[Persons with Mild Mental Retardation] 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. By 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.

(*Id.* at pp. 42 - 43.)

10. Regarding the differential diagnosis of Borderline Intellectual Functioning (IQ level generally 71 to 84), the DSM-IV-TR states:

Borderline Intellectual Functioning describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

(*Id.* at p. 48.)

11. Claimant performed in the average to low average range (normal range) in all areas of intelligence with the exception of verbal abstract reasoning, where he tested in the borderline range. His academic skills were below grade level given his intelligence level. Claimant's social skills were in the average to low average range (normal range) and his self-help (daily living) and communication skills were in the borderline range. Dr. Walker attributed the weakness verbal abstract reasoning to a Learning Disability. There is insufficient evidence to conclude that Claimant has significant subaverage general intellectual functioning and significant limitations in adaptive functioning based upon the foregoing evidence.

12. The DSM-IV-TR also provides that to establish mental retardation, there must be significant limitations or deficits in adaptive functioning in at least two of the skill areas specified in Paragraph 9 above. "Adaptive functioning" refers to whether a person can effectively cope with common life demands and can meet the standards of personal independence expected of someone their age, sociocultural background, and community setting. The Vineland II was used to measure Claimant's adaptive functioning levels. Claimant scored in the borderline range for communication and daily living skills and the average range for social skills. Although Claimant displayed significant issues with anger and aggression, such as frequent temper tantrums and fighting with siblings and school friends, these behaviors were associated with his diagnosis of ADHD and ODD. Claimant displayed good communication skills, although his communication was limited to areas of his own interests, and he was generally described as being able to dress and feed himself independently, perform some chores at home, and possessed an awareness of dangerous things like knives. Claimant possessed a common sense of safety awareness and does not require constant supervision by his Mother. Claimant is also fully ambulatory and does not have a serious medical condition that impacts his health.

13. Accordingly, given Claimant's present low average to average range (normal) of intellectual functioning, and his normal to borderline range of adaptive functioning skills, there is insufficient evidence to conclude that Claimant is eligible for regional center services based upon a diagnosis of mental retardation.

*Fifth Category*

14. Under the fifth category, the developmental disability must be “closely related” or “similar” to mental retardation, or “requires treatment” similar to that required for mentally retarded individuals. As stated above, there must be a significant degree of cognitive and adaptive deficits to establish mental retardation. Thus, to be closely related or similar to mental retardation, there must also be significant cognitive and adaptive deficits for an individual to be deemed to have a disability like that of a person with mental retardation. Although this does not require strict application of all of the cognitive and adaptive criteria utilized in establishing mental retardation, there must be evidence of significant deficiencies in cognitive and adaptive functioning. That is not the case here. Claimant’s test scores indicated that he is scoring generally in the normal range for cognitive functioning and in the normal to borderline range for adaptive functioning. Eligibility under the fifth category requires a showing that the cognitive and adaptive functioning has an effect or impact on Claimant that renders him like a person with mental retardation. There is insufficient evidence to conclude that Claimant’s cognitive and adaptive skill deficiencies render his disability similar to a person with mental retardation. Claimant’s deficiencies in cognitive and adaptive functioning properly supported a diagnosis of ADHD, ODD and Learning Disability. Claimant presented no evidence to contradict these diagnoses.

15. Claimant’s social assessment and psychological evaluation did not make recommendations that would typically be considered “treatment similar” to persons with mental retardation. Dr. Walker recommended that Claimant continue counseling and psychiatric care with CFGC for his ADHD and ODD, and that Mother receive parent skills training, and Claimant behavior therapy, to address his anger management problems. Given Claimant’s good medical condition and history, there were no treatment recommendations made relative to health concerns. The recommended treatments sought to address ADHD, ODD, and Learning Disability, and do not constitute treatments similar to that which would be required for a person with mental retardation. Claimant presented no evidence to the contrary, and therefore, a fifth category basis for eligibility was not established.

16. Claimant has not established that he qualifies for regional center services based upon a diagnosis of mental retardation, fifth category eligibility, or an Autistic Disorder, by reason of Factual Findings 1 through 19, and Legal Conclusions 1 through 15. Claimant has been diagnosed with ADHD, ODD, and a Learning Disability. These are not qualifying developmental disabilities upon which Lanterman Act eligibility may be based. Consequently, the Service Agency’s denial of Claimant’s eligibility must be upheld.

////

////

////

////

ORDER

The Service Agency's determination that Claimant Keishawn J. is not eligible for regional center services is upheld. Claimant's appeal is denied.

DATED: May 13, 2013



---

MICHAEL A. SCARLETT  
Administrative Law Judge  
Office of Administrative Hearings

NOTICE

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