

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

NORTH BAY REGIONAL CENTER,

Service Agency.

OAH No. 2014120589

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Napa, California, on August 27, 28, September 1 and 2, 2015.

Jack Bengé, Attorney at Law, represented the Service Agency, North Bay Regional Center (NBRC).

Carolyn Mackens, Attorney at Law, represented claimant who was not in attendance.

Oral and documentary evidence was received. Submission of this matter was deferred pending receipt of closing briefs. NBRC's Closing Argument and Claimant's Closing Brief were timely submitted, and marked respectively as Exhibits Q and 123. The record was closed and the matter submitted for decision on September 21, 2015.

ISSUES

Is claimant eligible to receive regional center services and supports because he is an individual with autism or an intellectual disability, or based on the "fifth category" because he has a condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability pursuant to Welfare and Institutions Code section 4512? ¹

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

FACTUAL FINDINGS

1. Claimant is a 30-year-old man, born in 1984. He resides in the family home with his parents and 34-year-old sister and has never lived independently. Claimant does not require assistance for dressing, grooming, hygiene or toileting but may require prompting. He performs simple household chores, again with prompts and /or supervision. He has been unable to obtain a driver's license and use of public transportation is reported to be limited to one "over-learned" BART route. Claimant has limited friendships and plays video games for the majority of his day. He has been unable to obtain employment and his money management skills are limited.

2. It was agreed, without exception, by all participants in this hearing that claimant is clearly impaired in his adaptive functioning. NBRC specifically stipulated to the fact that claimant has been impacted by his adaptive skills deficits. There is concern by all regarding his ability to care for himself, especially when his parents are no longer able to care for him. Claimant requires assistance; however the issue to be determined here is whether he qualifies for regional center services and supports.

3. Claimant's position is that he qualifies as an individual with autism, an intellectual disability, and/or a disabling condition closely related to intellectual disability, or that requires treatment similar to that required for individuals with an intellectual disability (commonly referred to as the "fifth category"). He contends that he lacks the capacity to live independently, due to major impairment in cognitive and social functioning, with limitations in areas including self-care, self-direction, capacity for independent living and economic self-sufficiency and learning.

4. NBRC contends that claimant does not meet the requirements for autism or intellectual disability. Nor is he eligible under the "fifth category" because his deficits in adaptive functioning are not attributable to global cognitive deficits, thus he does not have a condition closely related to intellectual disability. NBRC opined that claimant does not require treatment similar to that required by persons with intellectual disability.

5. Claimant initially sought regional center services in 2011, at age 26. The NBRC Initial Social Assessment, conducted in October 2011 by Assessment Counselor Dale Carr, M.S., noted that the California Department of Rehabilitation (DOR) referred claimant to NBRC because "they reportedly were unable to serve him as he needs more help and [*sic*] they are able to give him."

Ms. Carr noted that Laeeq Evered, Psy.D, reportedly diagnosed claimant with Asperger's disorder in March 2009. However, "the report was not thorough enough for us to accept the diagnosis." She ultimately concluded that she would order a referral "to rule out whether or not [claimant] has an autism spectrum disorder. If he is eligible for services I feel he

could benefit from some type of supported work program and supported living situation in the future.”

6. NBRC referred claimant to Licensed Clinical Psychologist Robert Horon, Ph.D., a regional center vendor, who completed his evaluation of claimant on December 14, 2011. Dr. Horon’s report included the following as Reason for Referral:

According to the NBRC referral, [claimant] was referred for testing to determine whether a diagnosis of an Autism Spectrum Disorder is present. The referral states that [claimant] was diagnosed with Asperger’s Disorder at age 24 by Clinical Psychologist Laeeq Evered, Psy.D. although it is noted that Dr. Evered did not complete standardized testing designed to evaluate for the presence or absence of an autism spectrum disorder, and the report ‘doesn’t address DSM-IV criteria’. Present concerns mentioned in the referral included an inability to maintain employment, even with the help of support agencies, a need for goal-directed activities, and a history of special education services throughout childhood and adolescence.

7. Dr. Horon’s report indicates that he administered standardized testing, and interviewed claimant and his mother, which also “included an abbreviated administration of the Autism Diagnostic Interview -Revised (ADI-R),” and reviewed available records, including the following:

- Neurodevelopmental Assessment report by William Blair, M.D., dated 4/6/01
- Psycho-educational Evaluation by Shelley Patnoe, Ph.D., School Psychologist, Sequoia Union High School, dated 4/18/02
- Individual Education Plan, San Mateo County SELPA², dated 5/15/02
- Testing Report, Sequoia Union High School, dated 6/3/03
- ‘Significance of Disability Determination’ by Catherine Garbacz, Department of Rehabilitation, dated 9/24/03
- Situational Assessment Authorization Summary by Todd Williams, Dreamcatcher Staff, dated 1/31/08
- Staffing Notes, Department of Rehabilitation, dated 4/11/08
- Psychological Evaluations (2) by Sherry Lebeck, Ph.D., Department of Rehabilitation, dated 7/30/08 and 11/26/08
- Summary Report of Neuropsychological Consultation by Laeeq Evered, Psy.D. dated 3/13/09
- Initial Social Assessment by Dale Carr, NBRC Assessment Counselor

² Special Education Local Plan Area.

8. Dr. Horon ultimately concluded that claimant's "symptoms reported do not meet the diagnostic threshold for an Autistic Disorder or an Autism Spectrum Disorder . . ." The NBRC eligibility team then determined that claimant was not eligible for regional center services. A Notice of Proposed Action (NOPA) was issued on January 19, 2012, informing claimant as follows:

Reason for action: You are not eligible for North Bay Regional Center services because you are not substantially handicapped by cerebral palsy, epilepsy, autism, mental retardation, or a condition similar to mental retardation

9. Claimant did not appeal NBRC's decision.

10. In 2014, claimant presented "new information" and again requested regional center services. Included were reports from April Young Ph.D., John Gasperoni Ph.D., and Anne Khalifeh Psy.D. A NOPA was issued on November 13, 2014, again informing claimant that he did not meet the eligibility criteria to qualify for services.

11. Claimant appealed NBRC's decision and this fair hearing ensued.

12. A Fair Hearing-Informal Meeting was held on January 27, 2015. The NBRC Legal Specialist/Hearing Officer considered the evidence presented, including additional information provided at the Informal Meeting, and issued the following ruling:

[Claimant] is extremely fortunate to have the love and support of what sounds like a truly caring and loving extended family. It is clear [claimant] has had, and will have, difficulties in his life. However, after reviewing the testimony and all the documents submitted in this hearing, it is this hearing officer's opinion that [claimant] does not meet the legal requirements to establish the existence of a Developmental Disability prior to the age of 18, and as such, he is not eligible for services.

The evidence presented in this Informal Meeting does not show that [claimant] possesses the qualifying conditions as set forth by the California Legislature for eligibility for Regional Center Services, which require a showing that the individual is Developmentally Disabled as defined under the Lanterman Act. There is no evidence that [claimant] has a diagnosis of Intellectual Disability (ID) prior to the age of 18. Before turning 18, he has not been proven to have a condition closely related to ID, nor was he shown to require treatment that is required by persons with ID. He does not have a clinical diagnosis of ASD. Without any diagnosed underlying condition that renders [claimant] similar to

one with ID or to require services that one with ID requires, his adaptive deficiencies alone do not render him developmentally disabled under the 5th category or ASD. Further, he is not diagnosed with Cerebral Palsy or Epilepsy.

...the possibility of ‘benefiting’ from regional center services also does not create eligibility. Many people might benefit from the array of services provided by the regional center, whether or not they are diagnosed as Developmentally Disabled.

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

“Developmental disability” means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual...[T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability³ 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.

14. 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 Effective January 1, 2014, the Lanterman Act replaced the term “mental retardation” with “intellectual disability.” California Code of Regulations, title 17, continues to use the term “mental retardation.” The terms are used interchangeably throughout.

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

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

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

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

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

15. 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.

16. 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.

ASSESSMENTS AND EVALUATIONS PRIOR TO DR. HORON'S DECEMBER 2011 EVALUATION.

17. January 1988 Children's Health Council Speech and Language Progress Report. Claimant was referred to the Children's Health Council for a speech and language evaluation by Margot Arana, M.A., Speech and Language Pathologist, who became aware of possible delays while working with claimant's sister. Claimant was found to have early language delays and "began to use words at approximately 1½ to 2 years of age. After that, he added words slowly. His first 2-word combination was heard at approximately 26 months of age. Speech and language were evaluated 8/11/87,⁴ and at that time, expressive language and phonological development were at the 22 month level." He "began speech and language therapy 9/16/87."

⁴ The Children's Health Council Examiner, Marsha Silver, M.S., C.C.C., recommended speech and language therapy at least twice per week due to claimant's delayed expressive language and phonological development. At this initial assessment the examiner reported that claimant "related well to the examiner. His attention for play was good. [Claimant] was able to stay with toys for an extended period of time. He engaged in age appropriate symbolic play, creating short schemes with Sesame Street figures. [Claimant] was able to speak for these figures and engage in pretending schemes with an adult."

Unlike his ability to attend to unstructured tasks, his concentration for and interest in formal testing was minimal, "he would not comply and became very active when this structure was imposed on him." The examiner concluded that "his resistance to formal testing requires further examination."

Children's Health Council Speech and Language Pathologist Christine Bate, M.A., C.C.C., concluded as follows:

Summary

[Claimant], age 3:2, has receptive language within the normal range. There are significant delays in expressive language and phonological development. Expressive language is at the 27-30 month level and phonological development is at the 24-26 month level.

Recommendation

[Claimant] needs consistent and intensive daily speech and language remediation. Therefore, it is recommended that he be enrolled in a Special Day Class for Communicatively Handicapped Children.

Claimant's hearing was also a concern at this time. His hearing was evaluated and found to be within normal limits. It was later determined that his hearing was affected by recurring ear infections and tubes were surgically placed in his ears.

18. November 16, 1992 WISC-III Report by Pauline Austin Adams, Ph.D. At age seven years, eleven months, claimant was "referred for a Wechsler Intelligence Scale for Children-Third Edition (WISC-III) administration as part of his participation in The Charles Armstrong School's program."⁵

Dr. Adams described claimant's test behavior as being "attentive while working on tasks, and he worked with good persistence. He seemed, however, to have some difficulty with sustained attention in that he frequently asked when he would be finished, how much more there was to go, etc."

On the WISC-III, claimant received a Verbal IQ Score of 81, a Performance IQ score of 79 and a Full Scale IQ score of 78. Dr. Adams offered the following:

SUMMARY AND CONCLUSIONS

On the WISC-III [claimant] achieved a Verbal Scale IQ Score in the Low Average category, and Performance and Full Scale IQ Scores in the Borderline category. His Full Scale IQ Score is at the 7th percentile. [Claimant's] subtest scaled scores ranged between Average and Very Low. He was relatively strong on

⁵ The Charles Armstrong School is a private school focused on serving students with language based learning differences.

some of the Verbal Comprehension subtests, tests of information, and some tests involving visual attention. [Claimant's] scores were very low on the test of abstract verbal concepts, the test involving copying abstract designs [*sic*] using blocks, and the test of counting and mental arithmetic.

It is recommended that additional testing be carried out to evaluate [claimant's] verbal and non-verbal intellectual functioning so that realistic goals for his academic progress can be set.

19. November 22, 1994 San Mateo County SELPA Speech and Language Individualized Education Program (IEP), Assessment of Present Levels of Performance. While claimant attended a third/fourth grade class, (nine years, eleven months), at The Charles Armstrong School, he was referred by his mother to the San Carlos School District for a "speech and language evaluation because of language processing difficulties."

Lynn Yap administered the Listening Test to evaluate claimant's ability to comprehend information that he hears, the Expressive One-Word Picture Vocabulary Test-R to assess ability to name black line drawings, and the Clinical Evaluation of Language Fundamentals-Revised (CELF-R) to assess receptive and expressive language abilities.

Ms. Yap stated that claimant "was shy when he first arrived for his language evaluation and had to be coaxed out of hiding in the bathroom. There was no direct contact between [claimant] and the examiner during the first session, but [claimant] would occasionally glance over out of the corner of his eye. He also frequently looked over his shoulder at mom for reassurance. By the second session however, his shyness had decreased and his social contact improved."

Claimant was also observed in his class at The Charles Armstrong School where his attention was described as "limited." He is "in frequent movement such as moving his head, shaking his hair, twiddling his pencil, snapping his fingers, bending back in his chair. He also makes noises and grimaces such as squeaking, or motor sounds similar to the play of a young child. At times when asked, 'Are you listening?' He pulls his ear out or pretends to put on listening ears. His teacher reports that [claimant's] desk is usually disorganized. [Claimant] prefers to play with children one or two years younger than himself." He "appears to need guidance at transition times. When he first came into class, he spent time wandering around and did not follow directions to 'hand in homework,' or 'write your name on the paper.' When the directions were put to him specifically by the teacher he was able to comply. Similar behavior was noticed at the beginning of P.E. All the boys went out to play hockey and [claimant] wandered around playing chase and poking another boy for fun and needed to be individually directed to the activity by the teacher."

Ms. Yap concluded:

Summary and Recommendations

[Claimant's] performance on the language evaluation reveals that he has a significant weakness in attention and auditory comprehension. These receptive difficulties also interfere with his ability to express himself. Speech and language therapy is recommended at this time in order to strengthen listening skills, auditory processing, concept development, and pragmatic language abilities.

20. January 31, 1996 Letter from Thomas Nachbaur, M.D., M.P.H. Claimant's physician Dr. Nachbaur diagnosed claimant with:

1. Speech and Language Disorder,
2. Dyslexia, and,
3. Attention Deficit Disorder with Hyperactivity.

Dr. Nachbaur explained that claimant's "Attention Deficit Disorder was diagnosed January, 1992. After a trial of Ritalin he was started on Cylert which he still takes at maximum doses. He was started on Wellbutrin in 1995."

21. May 16, 1996 San Mateo County SELPA Speech and Language IEP, Assessment of Present Levels of Performance. Claimant returned to San Carlos School District and was assessed by Carol Wong, while attending a fifth grade Special Day Class (SDC) at Brittan Acres School. Ms. Wong administered the CELF-R and compared scores with that obtained by Ms. Yap in 1994:

	1994	1996	1994	1996
Subtests	Standard Score		Percentile	
Concepts and Directions	3	5	1%	5
Word Classes	5	7	5	16
Semantic Relations	6	5	9	5
RECEPTIVE LANGUAGE SCORE	65	72	1%	3%
Formulated Sentences	4	9	2	37
Recalling Sentences *1995 ⁶	*5	4	*5	2
Sentence Assembly	*7	8	*16	25%
EXPRESSIVE LANGUAGE SCORE		82		12%
TOTAL LANGUAGE SCORE		75		5%

⁶ 1995 test scores were provided by report. In addition, Ms. Yap did not provide an Expressive Language or Total Language Score in her 1994 evaluation.

Also administered was SCAN, a screening tool for auditory processing disorders. Claimant received a SCAN Composite score of 93 that placed him in the 32nd percentile, with 100 being average. Ms. Wong concluded:

SUMMARY AND RECOMMENDATIONS

[Claimant] has made some progress in understanding word relations and in communication. His auditory processing skills were seen to be in the average range, although short-term auditory memory and attention and focusing problems affect his performance. He still shows weaknesses in receptive language which could make him eligible for pull-out services. It is recommended that the team weigh development of oral skills with what he can learn through the more inclusive program in the SDC classroom.

22. April 4, 2001 Neurodevelopmental Assessment report by William Blair, M.D. Dr. Blair reported that claimant was referred for this assessment by his pediatrician, Dr. Rick Lloyd. Assessment was first suggested by Claimant's RSP teacher, Marilyn Moran. Claimant was 16 years, 4 months and in the tenth grade at the time of this assessment.

Dr. Blair concluded:

SUMMARY AND FORMULATION:

ACADEMICALLY HE IS SERIOUSLY DELAYED, despite having received Special Education Services from kindergarten until the beginning of this school year, medication for his attention problem from first grade, until the beginning of the present school year, and counseling. READING is his strongest area, with a relatively good sight vocabulary. Reading comprehension is stronger than his ability to summarize and retell what he has read. Decoding unknown words phonetically is significantly delayed. WRITING: He writes as little as possible. He uses an awkward pencil grip. Actually he limits both written and verbal output. Spelling is delayed. MATH: Is particularly weak. He has not mastered subtraction with regrouping, multiplication of multiple digit numbers, or division. Nor has he fully mastered the multiplication tables.

SUMMARY OF NEURODEVELOPMENTAL PROFILE:

WEAKER AREAS, (relative) include:

1. MEMORY DYSFUNCTION, combination of:

- A. Insufficient Active Working Memory, and
- B. Difficulty Processing Large Chunks of Information, (Small Chunk Size Capacity).

In Combination with:

- 2. ATTENTION DEFICIT, predominately INATTENTIVE IN TYPE.
- 3. DIFFICULTY PRODUCING WRITTEN OUTPUT.

STRENGTHS (relative), include:

- 1. RECEPTIVE LANGUAGE, provided attention is well focused, and information is not in large complex chunks.
- 2. MOST ASPECTS OF MEMORY, including Short-term Visual and Auditory Memory, Visual Retrieval Memory, and Word Memory, again provided attention is well focused when information is received.
- 3. GROSS MOTOR, AND FINE MOTOR FUNCTION.

Dr. Blair notes that claimant “was diagnosed as having ADHD in first grade by psychiatrist Dr. Griggs, and despite medication, counseling, and special educational support has continued to present behavioral concerns and to be significantly delayed in academic achievement. Medication with Ritalin was started in first grade by Dr. Griggs, but was not well tolerated, (apparently resulted in severe rebound symptoms). Ritalin therefore was changed to a combination of Wellbutrin (150 mg.) and Cylert (75 mg.) which he received from grade 1 until the summer of 2000 when they were discontinued.”

On the parent-reported University of Massachusetts Clinical Interview completed by claimant’s mother, claimant received 12 out of 14 “yes” answers of diagnostic criteria for ADHD; eight or more are considered to represent a significant ADHD problem.

Claimant began tenth grade mainstreamed and without medication, both for the first time. He had a difficult time and was quickly transferred to “The Academy” program at Sequoia High School with a smaller class size. Claimant reported being bullied. Dr. Blair stated that claimant “continued to flounder, and has been very unhappy, somewhat depressed, frequently refusing to go to school (stays home), and feels harassed and upset by students who tease him. Currently he is failing most, if not all, of his subjects.”

23. 2002 Sequoia Union High School District Psych-Educational Evaluation by School Psychologist Shelley Patnoe, Ph.D. At age 17 and in eleventh grade, claimant was referred to Dr. Patnoe for assessment “to provide information for the three year review of [claimant’s] special education placement and services.” Dr. Patnoe explained that claimant was first identified as a student with special education needs as a preschooler and attended the county Early Childhood Education Program for children with severe disorders of language.

Once he entered school, he was again assessed and found eligible for support due to severe learning disabilities and was placed in a special day class in first grade. She noted that this assessment was the fourth re-evaluation of claimant’s special education and services, as he had an extensive history in special education.

Dr. Patnoe administered the Wechsler Adult Intelligence Scale (WAIS-III), Developmental Test of Visual Motor Integration (Beery), Test of Auditory-Perceptual Skills (TAPS), and reviewed the Woodcock-Johnson III (WJ-III) Tests of Achievement completed by Nancy Green RSP, at Sequoia High School.

WAIS findings:

<u>IQ Area</u>	<u>Standard Score</u>	<u>Percentile Ranking</u>
Full Scale	82	12
Verbal IQ	78	7
Performance IQ	90	25
Verbal Comprehension	89	23
Perceptual Organization	89	25
Working Memory	63	<1
Processing Speed	81	10

Dr. Patnoe concluded as follows:

[Claimant’s] performance indicates nonverbal skills that are in the average range when compared with others his age. His verbal development, however, falls in the below average range. A significant strength is seen on a measure of nonverbal reasoning and planning ability requiring the sequencing of visual information in order to anticipate outcome. Significant weaknesses were found on subtests that measure working memory: letter-number sequence, arithmetic and digit symbol coding. In fact, removing the influence of working memory from the Verbal Scale raises that score substantially, indicating low average verbal ability.

On the Beery, claimant received a Standard Score of 55, which “indicates skills that are significantly below average when compared with others his age.” Claimant received a TAPS Auditory Quotient of 63, which “indicates very poor skills in this area. His difficulty being able to repeat numbers, sentences, and words is an additional indication that his working memory is significantly below average when compared with others his age.”

Dr. Patnoe addressed claimant’s Social-Emotional functioning by stating that he “has a recent history of school refusal and attendance has been poor since his sophomore year. He was

referred for a mental health assessment and was found eligible for 26.5⁷ services. Informal observation suggests that the services are being effective as [claimant] appears much [more] energized and happier than in previous months.”

WJ-III results, Dr. Patnoe noted, were consistent with previous assessments, and Ms. Green’s findings indicated low academic achievement across all domains. Claimant’s composite scores were as follows:

<u>Composite Area</u>	<u>Standard Score</u>	<u>Percentile Ranking</u>
Broad Reading	69	2
Broad Math	50	<1
Broad Written Language	61	.5
Total Achievement	70	2

“There is a significant discrepancy between [claimant’s] low average cognitive development (when effects of his poor working memory are removed) and his achievement in all academic areas. His visual-motor skills were found to be significantly below average when compared with others his age. His working memory for auditory information is significantly weak. [Claimant] needs to be presented with information visually whenever possible.”

“It is recommended that he continue with maximum special education support. The most important task ahead will be planning for [claimant’s] transition from high school. He has skills and abilities related to working with computers and with careful planning should be able to function well (and happily) in the working world.”

24. July 30, 2008 Psychological Evaluation by Clinical/Vocational Psychologist Sherry Lebeck Ph.D. Claimant was 23 years old when he was “referred for psychological testing by his vocational rehabilitation counselor at the Department of Rehabilitation (DOR) in order to assess his cognitive strengths and weaknesses, interests, and personality.” This information was obtained to assist in determining the appropriateness of vocational rehabilitation for claimant. Dr. Lebeck administered the Wide Range Achievement Test-Expanded Edition (Level 5) (WRAT-5), Beck Depression Inventory-Second Edition (BDI-II), and Rotter’s Incomplete Sentences Blank (RISB).

Several pages were missing from this evaluation and the results of the standardized tests were not available for review. Dr. Lebeck did note that claimant was “cooperative throughout the testing procedure, with good eye contact. . . On two occasions, he requested a time-out to take medication ‘for concentration.’ Although ADHD testing was requested on this client, it was not completed since the required materials were not accessible at the time. It was apparent that [claimant] has a problem with concentration such as that associated with ADHD, since he required medication ‘for concentration’ in order to complete the testing process.”

⁷ 26.5 refers to a program providing school-related mental health services.

25. November 26, 2008 Psychological Evaluation by Clinical/Vocational Psychologist Sherry Lebeck Ph.D. Dr. Lebeck was again referred claimant's case. She administered the Wechsler Abbreviated Scale of Intelligence (WASI), which was "designed for quickly and accurately estimating an individual's intellectual functioning and for screening purposes." She also administered Draw a Person/Tree/House/Bicycle/Clock, and conducted a clinical interview.

On the WASI claimant received a Verbal IQ Score of 82, a Performance IQ score of 92 and a Full Scale IQ score of 85. Dr. Lebeck offered the following:

DSM-IV-TR⁸ Diagnosis:

Axis I	314.9	Attention-deficit, Hyperactivity Disorder, previously diagnosed
Axis II	799.0	Deferred
Axis III		Possible Traumatic Brain Injury

Discussion

[Claimant's] testing reflects a Low Average Full Scale IQ. There was not a significant difference between his Verbal and Performance IQ. The client indicated that he was in special education classes throughout his school years, but he was unclear why he was placed in those classes. Because of time constraints, this examiner selected intellectual testing and projective drawings in an attempt to better understand this individual.

While sitting with [claimant], he did not display the usual symptoms of someone with a diagnosis of ADHD. He was

⁸ The Diagnostic and Statistical Manual of Mental Disorders, Forth Edition, Text Revision (DSM-IV-TR) was the standard for diagnosis and classification at the time of this evaluation. 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

cooperative and was able to focus and complete tasks (block design/matrix reasoning), although slow. The thing that was interesting was that this client had difficulty with memory. He could not remember what medication he was taking, his person in the house/tree/person drawing did not know what he was thinking, and he was unable to put the hands of the clock at the appropriate time requested. He also had trouble with attention to connections and detail as seen in his person, clock, and bicycle drawings.

Claimant informed Dr. Lebeck that he came to the DOR to “find a job.” He explained that he had only held one job, as a courtesy clerk for Raley’s, which “just wasn’t for me. It was too stressful.” He reportedly quit after approximately one month because he feared being fired.

Claimant also informed the examiner that he ‘fell and hit his head on ice around the age of eight or twelve.’ He reported that he was not knocked out but “had a very bad headache for awhile.” Dr. Lebeck questioned whether he sustained a brain injury but noted that ‘a complete neurological work-up would be required to make a definitive diagnosis of a brain injury.’⁹

26. March 13, 2009 Summary Report of Neuropsychological Consultation by Clinical Psychologist/Neuropsychologist Laeeq Evered, Psy.D. Dr. Evered reported that the reason for claimant’s referral was that he “is a 24-year-old man with a history of social, educational, and occupational impairments that significantly impact his independent living skills. A neuropsychological consultation was requested to assist with diagnostic clarification and treatment interventions.” He conducted a clinical interview, a collateral interview with claimant’s mother, administered the Rey-Osterrieth Complex Figure test (ROCF) and reviewed records (five). Dr. Evered’s evaluation did not include formal standardized testing, apart from the ROCF. His two-page report concluded as follows:

DIAGNOSTIC IMPRESSIONS

Axis I:	299.8 Asperger’s Disorder 314.01 Attention Deficit/Hyperactivity Disorder, Combined Type
Axis II:	799.9 Diagnosis Deferred on Axis II
Axis III:	History of Allergies
Axis IV:	Limited social support, restricted activities of daily living, occupational impairments
Axis V:	GAF=50

Dr. Evered included the following in his Summary and Conclusions:

⁹ Claimant’s family did not substantiate this injury and brain injury was no longer a concern.

Subsequent to a thorough review of prior testing in conjunction with diagnostic and collateral interviews, [claimant's] global impairments in occupational and daily functioning are judged consistent with Asperger's Disorder. His primary deficits fall within the neurocognitive domains of executive functioning and social processing. [Claimant] has greatest difficulty with planning, initiating, organizing, understanding, and carrying out activities beyond that which would solely be explained by AD/HD. Although an extremely polite individual who may give the appearance of understanding speech and social interactions, his true comprehension in these areas is estimated to fall within the severely impaired range and represent a significant area of deficit.

Due to the degree of his impairments, it is highly recommended that he be afforded assistance and accommodations with respect to occupational training and placement. A thorough vocational assessment is highly recommended in order to determine [claimant's] areas of strengths that will permit him to function to the highest level of his ability. It will be critical that he be placed in an occupational environment with limited demands for social interaction. Due to the nature and degree of his disorder, assistance with job placement will also be required. [Claimant] retains areas of strength. As such, he may benefit from academic training such as through Diablo Valley College. It will be critical that all services address [claimant's] limited organizational capacities and social comprehension and expressive deficits.

DR.HORON'S DECEMBER 24, 2011 PSYCHOLOGICAL EVALUATION REPORT.

27. December 24, 2011 Psychological Evaluation report by Clinical Psychologist Robert Horon Ph.D. As a result of claimant's initial eligibility request in 2011, he was referred by NBRC to Clinical Psychologist Robert Horon, Ph.D., who completed his "best practice"¹⁰ evaluation of claimant and issued his report on December 24, 2011. Claimant was 27 years old and referred to determine whether or not a diagnosis of an Autism Spectrum Disorder was warranted. Dr. Horon administered the Adaptive Behavior Assessment System-II (ABAS-II), Autism Diagnostic Observation Schedule-Module 4 (ADOS), and the Autism Diagnostic Interview-Revised (ADI-R).

Dr. Horon reported the following behavioral observations:

¹⁰ The Best Practice Guidelines for Screening, Diagnosis and Assessment of Autism Spectrum Disorders was published by the California Department of Developmental Services (DDS) in 2002.

[Claimant] was met in the waiting room and responded to my greeting with eye contact and appropriate small talk. He shook hands and was friendly in his greeting. [Claimant] accompanied me to the interview room, and seemed comfortable and even a bit outgoing socially. Rapport was established easily and was maintained throughout the interview. [Claimant] mentioned feeling a bit anxious, but there were minimal objective signs of anxiety. [Claimant] clearly enjoyed interacting, and evidenced a very good sense of humor. He seemed open and engaged in talking about himself, his goals, and his relationships. He stated ‘I feel better when I’m interacting with people.’ [Claimant] used non-verbal gestures to aide communication repeatedly, and these were well integrated with speech and facial expressions. [Claimant] was casually dressed and adequately groomed for interview.

[Claimant] had noticeable problems with inattention during the current evaluation. He also exhibited some word finding difficulties. Stereotyped behaviors, interests, and abnormal behaviors were not observed. Specifically, I did not observe [claimant] engage in any unusual sensory interests, engage in hand or finger manners, or engage in self-injury. He did not have significant preoccupations, and did not present with any compulsion or ritual.

[Claimant] gave adequate effort on all tasks. He seemed to want to do well and appeared to enjoy the testing situation. Overall, [claimant] was motivated and cooperative with interview and testing procedures, and thus the testing completed appears to validly reflect current functioning.

The ABAS-II is an adaptive behavior measure used to assess adaptive skills functioning utilizing rating forms. Claimant’s mother was the informant. Based on those responses, claimant obtained a General Adaptive Composite standard score of 61, which is in the severely impaired range (1st percentile). Claimant’s results on all composite scores were:

Composite Scores (average composite scores are 90-110):

General Adaptive Composite	61	<1 st percentile
Conceptual Domain	67	1 st percentile
Social Domain	70	2 nd percentile
Practical Domain	69	2 nd percentile

Claimant obtained the following profile in the various skill areas (the average range for Individual Skill Areas scaled scores is 8-12):

<u>Conceptual</u>		<u>Social</u>		<u>Practical</u>	
Communication	5	Leisure	5	Community Use	3
Functional Academics	2	Social	4	Home Living	6
Self-Direction	5			Health and Safety	4
				Self-Care	4

Dr. Horon explained that “compared with typical level of skill development of individuals his age, [claimant] was rated as having impaired functioning across all domains. All scores are below [claimant’s] estimated level of cognitive functioning, with Functional Academic Skills the most deficient (which matches poor achievement test scores reported previously).”

The ADOS is a structured interview and observation technique that is considered the gold standard in diagnosing autism spectrum disorders. Dr. Horon explained that Module 4 was “designed for adolescents and adults who have fluent speech, defined as ‘producing a range of flexible sentence types, and providing language beyond the immediate context.’ [Claimant] proved to have adequate expressive language skills for Module 4, and thus Module 4 proved to be quite appropriate for him.”

In addition to the behavior observations previously noted, Dr. Horon reported the following:

[Claimant] appeared to rather enjoy taking the ADOS, and enjoyed interacting with the examiner on the ADOS activities. [Claimant] was first asked to tell a story from a book (during the ADOS), and laughed repeatedly while commenting on the pictures in the book. He welcomed comments from me and laughed at the book, ‘This is very interesting!’

[Claimant] was very open in discussing work and school experiences. Though he did struggle for words at times, I did not observe any echoed language or stereotyped or idiosyncratic use of words or phrases. [Claimant’s] speech was quite normal, with typical volume, rate, intonation, and rhythm. [Claimant] was interactive, offering information and maintaining reciprocal conversation. As noted previously, [claimant] also was able to integrate verbal and non-verbal gestural communication well.

[Claimant] exhibited good eye contact throughout the ADOS. He exhibited minor difficulties in describing his own affect, in having insight into his social impact on others, and in reporting a sense of responsibility for his behaviors. However, these difficulties were minor and were not characteristic of autism. Rather, they seemed

to be a function of immaturity and perhaps mild deficits in verbal ability.

Overall, [claimant] evidences few behaviors within each of the major symptom areas common in Autistic Disorders. His scores were below the autism and autism spectrum cut-off scores for the Communication Domain and the Reciprocal Social Interaction Domain of the ADOS. His Total Score on the ADOS is also below the autism and autism spectrum cut-off scores per the ADOS diagnostic algorithm for Module 4.

<u>[Claimant's] Scores</u>	<u>Cut-off Scores</u>
Communication Total: 1	Autism cut-off score: 3 Autism Spectrum cut-off score: 2
Social Interaction Total: 2	Autism cut-off score: 6 Autism Spectrum cut-off score: 4
Combined Score Total: 3	Autism cut-off score: 10 Autism Spectrum cut-off score: 7

On the ADI-R, Dr. Horon reported that from a diagnostic perspective, [claimant's] scores on the ADI-R comprehensive algorithm were inconsistent with a diagnosis of Autistic Disorder. His score summary on the interview administered with his mother was as follows:

- Qualitative Abnormalities in Reciprocal Social Interaction: 7*
Autism cut-off score: 10
- Qualitative Abnormalities in Communication: 6*
Autism cut-off score: 8
- Restricted, Repetitive, and Stereotyped Patterns of Behavior: 3*
Autism cut-off score: 3
- Abnormality of Development Evident at or Before 36 Months: 1*
Autism cut-off score: 1

Abnormalities in Reciprocal Social Interaction: [Claimant's mother] noted that at an early age [claimant] had hearing problems, severe speech delays, and difficulty making friends. He did not reliably respond to the approaches of other children, and relied on "tapping" to attempt to engage socially. He also had fine motor delays and needed mom to open things for him. He enjoyed interacting with his mother and sister, but less clearly so with others.

Abnormalities in Communication: [Claimant's mother] noted that [claimant] rarely pointed to express interest as a toddler. He has been relatively poor with social chat and conversation; "I have to

do most of the work to have a conversation with him.” [Claimant] also has some word finding problems and reversed pronouns as a toddler.

The *Restricted, Repetitive, and Stereotyped Patterns of Behavior* noted during the ADI-R included a possible hand mannerism and some sensitivity to sound and clothing texture.

Again, the symptoms reported do not meet the diagnostic threshold for an Autism Disorder or an Autism Spectrum Disorder, such as Asperger’s Disorder.

DSM-IV Diagnostic Impression:

- Axis I: 314.00 Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type, by history
315.9 Learning Disorder, Not Otherwise Specified, by history
- Axis II: V71.09 No Diagnosis on Axis II
- Axis III: None noted

Explanation of Diagnosis: [Claimant] was diagnosed with Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type and with severe Learning Disorders by previous evaluators. He was found to have severe working memory and auditory processing deficits in past evaluations as well. These disorders and deficits have historically been of sufficient severity to impact social, academic, and occupational functioning. It appears that these deficits continue to impact [claimant’s] functioning in a significant way.

Summary: [Claimant] is a 27-year-old male who was referred for diagnostic evaluation to determine whether he has an autism spectrum disorder. [Claimant] had early speech difficulties, hearing difficulties, and fine motor delays, and he was diagnosed with severe learning disabilities and ADHD during childhood. Testing during childhood and adolescence indicated severe working memory and auditory processing deficits. More recently, in 2009, a psychologist diagnosed [claimant] with Asperger’s Disorder. Most notably this diagnosis was made without specific testing for Asperger’s Disorder and without mention of DSM-IV diagnostic criteria.

During the present evaluation, [claimant’s] responses on a structured observation technique (ADOS) and his mother’s

responses on a structured interview (ADI-R) were not indicative of the presence of an Autistic Disorder. [Claimant] does not meet the diagnostic criteria for Asperger's Disorder.

Dr. Horon concluded his report with a series of recommendations, of which the following was particularly insightful:

[Claimant] has known deficit areas, and as such, clear targets for compensatory skill building. For example, working memory deficits are common in individuals with ADHD, and in fact can be seen as a core deficit in ADHD. As poor working memory contributes to multiple deficits (social, occupational, and academic), compensating for this deficit is crucial. Known steps for compensating for such deficits include:

- a. Selecting a memory strategy to train. Use of specific techniques, taught one at a time, works best.
- b. Conduct active modeling of memory strategies.
- c. Complete repetitive practice and overlearning of the strategy.*

*See, for example, Working Memory and Academic Learning: Assessment and Intervention by Milton Dehn.

It appears that [claimant's] deficits have been poorly recognized at times, and attributed to 'laziness' or lack of motivation. It should be understood that the severity of [claimant's] working memory and auditory processing deficits is rather profound, and that such deficits are typically pronounced across areas of functioning (i.e., social, academic, and vocational). [Claimant] will need rather significant supports, with sufficient time and repetition, to be successful in occupational settings.

ASSESSMENTS AND EVALUATIONS SUBSEQUENT TO DR. HORON'S DECEMBER 2011 EVALUATION.

28. July 7, 2012 Psychological Assessment Report by April Young Ph.D. The Department of Social Services referred claimant to Dr. Young for a psychological evaluation "to assist with determining his disability status." Claimant's response to the examiner's request to describe his disability was that he "is disabled due to ADHD." Dr. Young utilized the Bender Visual Motor Gestalt-II (Bender), Trail Making Test Part A and B (Trails), Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) and Wechsler Memory Scale-Fourth Edition (WMS-IV).

On the WAIS-IV, Dr. Young concluded that claimant "obtained a Full Scale IQ of 74,"¹¹

¹¹ Dr. Young provided a Full Scale IQ score but did not provide Verbal or Performance

which places his functioning in the 4th percentile and the borderline range,” with the following Index scores:

	<u>Composite Score</u>	<u>Percentile</u>
Verbal Comprehension Index	85	16
Perceptual Organization Index	77	6
Working Memory Index	71	3
Processing Speed Index	76	5

Reported WMS-IV Index scores follow:

	<u>Score</u>	<u>Percentile</u>
Auditory Memory Index	78	7
Visual Memory Index	71	3
Immediate Memory Index	77	6
Delayed Memory Index	66	1
Visual Working Memory	77	6

Dr. Young also reported that claimant obtained a standard score of 106 on the Bender, which falls in the average range. His performance on Trails was mildly impaired. She noted that, interpersonally, “the claimant was cooperative and pleasant. He put forth good effort during the evaluation.” The psychometric results were considered to be “a reasonably accurate representation of [claimant’s] current functioning. Overall, these test results suggest borderline cognitive functioning. His performance on measures of intellectual abilities ranged from borderline to average. There was a statistically significant difference among his composite scores. His performance on tests of memory fell within the extremely low to average ranges. His visual motor skills fell within the average range. His sequencing and tracking abilities were impaired.”

She concluded as follows:

DSM-IV Diagnostic Impression:

- Axis I: Attention-Deficit/Hyperactivity Disorder (by history)
Learning Disorder, NOS
- Axis II: Diagnosis Deferred on Axis II
- Axis III: Deferred to Medical Records

29. Claimant was subsequently denied eligibility for social security benefits and has retained counsel to assist in an appeal.

30. February 28, 2013 Neuropsychological Assessment by David O’Grady Ph.D. ABPP. At age 28, claimant was referred to Dr. O’Grady “to characterize his current

IQ scores.

neurocognitive functioning and clarify his diagnosis. Additionally, [claimant] and his parents are interested in identifying his relative strengths and weakness and assessing his capacity for work.” Dr. O’Grady recognized that claimant has a “history of severe learning disorder who has never worked or lived independently.”

After administering a series of testing instruments, clinical interview and records review, Dr. O’Grady made the following conclusions:

DIAGNOSTIC IMPRESSION:

1. Cognitive disorder, not otherwise specified (294.9).
2. Social anxiety disorder (300.23)
3. Attention deficit hyperactivity disorder, combined type (314.01)

WAIS-IV findings:

<u>IQ Area</u>	<u>Standard Score</u>	<u>Percentile Ranking</u>
Full Scale	80	9 (Low average)

Index Scores:

Verbal Comprehension	89	23
Perceptual Reasoning	92	30
Working Memory	74	4
Processing Speed	74	4

31. May 11, 2014 Neuropsychological Evaluation by Anne Khalifeh Psy.D. At age 29, claimant was referred to Dr. Khalifeh by his psychologist, Dr. John Gasperoni, for a “neuropsychological evaluation with regard to cognitive functioning and independent living skills.” Dr. Khalifeh explained that claimant “has a history of individual learning differences and has utilized special education services throughout his academic career. The patient has been unable to maintain employment or obtain assistance to find an appropriate position. The patient has undergone a number of psychological evaluations with varying diagnoses. The patient is seeking diagnostic clarification and would like additional support services.” Dr. Khalifeh noted that claimant “endorsed a history of outpatient mental health services since childhood” and is “currently under the care of Dr. Gasperoni (anxiety, social skills, employment issues).”

In addition to a Clinical Interview and Mental Status Examination, Dr. Khalifeh utilized the following: Trails A/B, Clox ½, Nelson Denny Reading Test (NDRT), Continuous Performance Reading Test (CPT,) WJ-III (Letter Word Identification, Reading Fluency, Math Fluency, Picture Vocabulary), ABAS-II, Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), WAIS-III subtests-Coding, Copy, Beck Depression Inventory-Second Edition (BDI-II), and Beck Anxiety Inventory (BAI). Psychometric findings were as follows:

The patient performed in the average range on a task of simple attention and visual scanning and in the moderately impaired range on a more complex measure of attention and executive function (Trails A, T=42, Trails B, T=26). Timed copy and coding tasks, a pure form of processing speed, were in the borderline to low average range (WAIS-III, DSC/SC, SS=5, >10%). On a measure of academic achievement, [claimant] demonstrated variable performance. When compared to his age/education related peers, he demonstrated impaired performance on math fluency skills and low average performance on measures of reading fluency and word identification. His performance on a measure of receptive vocabulary was in the average range (WJ-III: Math Fluency, SS=66, Letter Word Identification, SS=87, Reading Fluency, SS=84, Picture Vocabulary, SS=101). However, on a timed measure of vocabulary and reading comprehension skills, [claimant] evidenced variable performance, with his overall score in the low average range (NDRT: Total: T=43/25%, Comprehension, T=32/4%0. [Claimant's] reading rate was in the impaired range (NDRT: RR, T=27/1%).

[Claimant's] performance on measures assessing attention and concentration (CPT, WAIS-IV¹²/MR,SS), were WNL, which fails to support a diagnosis of ADHD and indicates difficulties existent in the areas of decoding, comprehension, integration and associative linkage which negatively impacts executive functioning and retrieval in all domains. On self-report measures of emotionality, [claimant] demonstrated anxiety and depression in the mild range (BDI-II and BAI).

On measures of adaptive functioning (ABAS, Vineland-II), [claimant] evidenced impaired scores on all domains including communication skills (T=<20), daily living skills (T=<20), socialization skills (T=<20) and motor skills (T=20). The performance profiles on these measures, independently assessed by both the IP and his mother, evidenced little variability and were largely in confluence across all domains.

Dr. Khalifeh concluded that claimant's "overall profile is consistent with his documented history of academic and social difficulties and their subsequent impact on his ability to find/maintain suitable employment." She noted that claimant's "current evaluative profile reveals profound impairments in all domains of independent living." She opined that

¹² Dr. Khalifeh reported administering the WAIS-III but scores reflect the fourth edition. (WAIS-IV).

claimant's "ADL profile (daily living skills) is functionally, at the age equivalent of an individual 3-5yo." She also voiced concern that "the adaptive effects of assisted daily functioning are not factored into the overall results in previous evaluative findings." Dr. Khalifeh suggested that claimant's variability in intellectual abilities indicated "mitigating factors, as opposed to core intellectual abilities." Specifically, "years of special resource/tutorial services, accompanied by the daily supervision of his activities by his parents, is reflected in his 'fund of knowledge' (Vocab/Info) and communication skills. As such, these reflect adaptive/compensatory strategies which are the methods of **compensation** that he has successfully internalized to facilitate daily functionality." (Bolding in original.)

Dr. Khalifeh offered the following diagnostic profile and treatment recommendations:

Axis I:	V79.9 Unspecified Mental Disorder & Developmental Handicap
Axis II:	799.9 Deferred
Axis III:	Acid reflux, Migraines, Low back pain, and Asthma
Axis IV:	Lack of access to appropriate supportive services, Employment problem
Axis V:	GAF=45

1. It is recommended that [claimant] undergo a full neuropsychological evaluation to definitively identify his learning differences and also effective learning strategies.
2. [Claimant] is in need of additional supportive services, including alignment with a sheltered workshop/job training and placement program.

32. January 22, 2015 letter from John Gasperoni, Ph.D. Claimant has been in treatment since July 2013 with Dr. Gasperoni, who was asked to write this letter as part of claimant's efforts to obtain regional center services.

In terms of his DSM V¹³ diagnosis, [claimant] presents the following clinical picture:

Axis I:	299.00 Autism Spectrum Disorder, Level 2
	319 Intellectual Disability, moderate to severe
	300.02 Generalized Anxiety Disorder
	300.4 Persistent Depressive Disorder
Axis II:	V71.09 No diagnosis
Axis III:	Acid reflux, migraine headaches, asthma, low back

¹³ The Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) was released in May 2013. Most notably, it changed the diagnosis of Mental Retardation to Intellectual Disability (Intellectual Development Disorder) and no longer uses a multi-axial system. The new classification system combines the axes together and disorders are rated by severity.

Axis IV: pain
Lack of access to appropriate supportive services,
inability to obtain and maintain employment, social
isolation and avoidance
Employment problem
Axis V: Severe

Prior to this letter, on August 28, 2013, Dr. Gasperoni completed a questionnaire for DOR where he provided the following diagnosis:

Axis I: 299.80 Asperger's disorder, active
300.02 Generalized anxiety disorder
300.4 Dysthemic disorder
Axis II: No dx
Axis III: No dx
Axis IV: No identifiable stressors at this time
Axis V: 49 current
49 past year

There was no diagnosis of Intellectual Disability made. A similar questionnaire was completed on February 11, 2014, in which Dr. Gasperoni responded that claimant's condition had not changed since his August 28, 2013 assessment. He continued to note "the high level of anxiety [claimant] constantly experiences."

33. June 18, 2015 Clinical Assessment and Review of Records by Clinical Psychologist Nancy Perry, Ph.D. Also at age 30, claimant was referred to Dr. Perry "to help [claimant's] family determine whether to pursue eligibility for Regional Center Services." -Dr. Perry obtained information from a thorough records review, interview/clinical assessment with claimant and interviews with claimant's mother, father and aunt. Her conclusion was that claimant "should be found eligible for Regional Center services under the fifth category because he has a developmental disability closely related to Intellectual Disability and he needs treatment approaches consistent with those provided to individuals with Intellectual Disability. [Claimant] has intellectual impairment, social impairment, and functional impairments that leave him unable to care for himself. He lives with his parents and is completely dependent upon them. He has no social life, no job, no practical skills, and no interests except video games. He does not drive, or exercise or cook or clean, and he cannot analyze what it would take to change his life. Without the care provided by his parents, [claimant] would be unhealthy, financially destitute, and unsafe."

Dr. Perry pointed to claimant's "diagnostic confusion" during his school years and questioned his ADHD diagnosis. She opined that "executive function impairments are [claimant's] main obstacle, along with his low intellectual capacity." "Working memory and short-term memory are executive function skills that support control of one's attention. [Claimant's] most consistently reported finding is severely impaired working/short-term

memory.” She described the importance of executive functions as “the manager of all other cognitive skills.”

In addressing claimant’s eligibility for special education as an individual with a Specific Learning Disability Dr. Perry opined:

I have reached the conclusion that [claimant] did absolutely as well as he could possibly do in school, given his Intellectual Disability. He showed strengths in vocabulary and word reading, but not in reading comprehension or retention; problem solving is better in the visual than aural mode but impaired in either mode. His disabilities are global rather than focused deficits as seen as Specific Learning Disorders¹⁴, and his global deficits include severe impairment in the important executive functions, as well as social skills. This presentation means that [claimant’s] challenges did not qualify for the label Specific Learning Disorder because his deficits are global rather than specific.

SCHOOL RECORDS

34. Claimant was first identified as a child with special education needs as a preschooler. Initially, he received speech and language services and attended the county Early Childhood Education program for children with severe language disorders. He attended a regular kindergarten class which was not successful, after which he was placed in an SDC for first grade.

35. Claimant attended The Charles Armstrong School for second through fourth grades, returning to public school in the fifth grade. For a portion of claimant’s sophomore year in high school he attended an “academy” program. His parents described that program as a “major mistake” which affected claimant in negative ways. Aside from the academy placement, claimant spent his public school years in an SDC. He graduated from Sequoia High School in June 2003. His official transcript contains the following comments:

4yrs Spec Ed math sub for math req. and 1 yr Reading sub for 1 yr of English req.waived per IEP 3/20/03

36. June 13, 1990 San Mateo County SELPA Individual Education Program IEP. This IEP documented the team decision to place claimant in a regular kindergarten with eligibility for special education based on a “speech and language handicapping condition.”

¹⁴ The special education eligibility category of Specific Learning Disability “means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations.”

37. September 21, 1990 San Carlos School District Assessment Report by School Psychologist Janet Urman Wohl and Resource Specialist Roberta Nelson. Claimant was referred for assessment after transferring to a regular kindergarten class after two years in the county ECE-SDL class. It “appeared appropriate to conduct a full assessment to determine whether RSP support would also be beneficial.” The assessors concluded:

SUMMARY AND RECOMMENDATION

[Claimant] is a 5 year, 9 month old kindergartner of at least low average nonverbal intellectual ability who has made significant gains in expressive language functioning after two years in the county ECE-SDL¹⁵ program. Although [claimant’s] attending behavior has also improved, attention is still difficult for him to maintain in a large classroom setting. Visual-motor integration skills also represent a significant weakness which [claimant] appears aware of. A severe discrepancy exists between [claimant’s] low average ability and his achievement in reading and math, which is two standard deviations below his grade level. [Claimant] clearly demonstrates deficits in the basic psychological processes of attention and visual-motor integration. As such, he qualifies to receive additional Special Education services at this time. Placement in the Resource Specialist Program for assistance with math, reading and written language appears appropriate, in addition to continuing speech and language services.

38. September 19, 1990 San Mateo County SELPA IEP. The IEP team reviewed assessment data attained during previous and recent assessments,¹⁶ and determined that claimant required RSP services in the areas of math, reading and written language, in addition to his speech and language services. The team found a “severe discrepancy exists between [claimant’s] ability and math and reading achievement scores. A weakness is also seen in visual-motor skills. [Claimant] demonstrates visual-motor and attentional processing deficits.” His eligibility for special education services was “SLD, visual-motor & attentional proc. Deficits, S & L.”

39. April 11, 1991 San Mateo County SELPA IEP. The IEP recommended that claimant receive special education services in a special day class (SDC) setting for first grade. Claimant “has made limited academic growth for this amount of RSP assistance. He continues to function at a pre- first grade level academically and in terms of fine motor skills. [Claimant’s] behavior is also of concern, as he has developed avoidance skills and has difficulty

¹⁵ Early Childhood Education-Severe Disorders of Language.

¹⁶ Formal report issued on September 21, 1990.

remaining still and maintaining attention.” Claimant remained eligible for speech and language services.

40. June 30, 1992-July 24,1992 Charles Armstrong School Summer School Report. Claimant participated in the summer program at CAS “to further assess the appropriateness of a simultaneously presented multi-sensory approach to learning, and to evaluate the possibility of full-time placement at CAS for the 92-93 school year.”

41. Charles Armstrong School Annual Goals Statement 1992-1993 School Year. Claimant began attending CAS as a second grader in a small structured classroom. It was also determined that he needed individual tutoring three days per week. His End of Year Statement summarized:

[Claimant’s] reading test scores reflect a very slight gain this year. On a daily basis he has made some reading gains especially in decoding words. Test scores indicate moderate gains in spelling and minimal math gains. These scores are consistent with his daily work in both areas. [Claimant] has made significant improvement in handwriting. He is able to produce accurately formed letters and numbers. However there is little carryover of this skill on a daily basis.

[Claimant] is learning to follow auditory and visual direction but he can be resistant to beginning and/or completing his lessons. He still needs to develop the skills leading to self-direction and he needs to be able to assume responsibility.

[Claimant] is able to interact with his peers and has made progress in developing social skills.

It was recommended that claimant attend the CAS summer program and continue with individual tutoring.

42. July 23, 1993 CAS End of Summer School Report. Claimant attended the summer program where it was noted that he “needs to be reminded to stay on task” and is “learning to stay on task and continuing to improve at a slow pace with extra reinforcement from the teacher.”

43. Charles Armstrong School Annual Goals Statement 1993-1994 School Year. During the third grade year, it was reported that claimant “has made gains in all areas this year.” He “continues to struggle with the kinesthetic-motor skills required for writing with fluidity and has difficulty with independent written expression. In math, [claimant’s] scores on the WRAT, Circus and Brigance test indicate his difficulty in understanding new concepts and applying them in computation.”

44. July 18, 1994 CAS End of Summer School Report. It was again recommended that claimant attend the CAS summer program. In that program he had difficulty “maintaining focus in an academic setting, and persisting when tasks are challenging.” He also exhibited difficulty with an “ability to learn at an appropriate pace in a class of 15 students with one teacher.” It was recommended that claimant have “1-1 tutoring in the fall to support and assist his classroom instruction.”

45. Charles Armstrong School Annual Goals Statement 1994-95 School Year. During this school year, claimant attended Mr. Osner’s 3rd/4th combination class. At the end of the year, it was determined that a “placement at Charles Armstrong School in the fall is not available that we feel will meet [claimant’s] academic and emotional needs. An ideal setting for [claimant’s] future education would consist of very small class sizes and remedial language support services.” Mr. Osner explained:

[Claimant] has made some progress this year that has been observed in the classroom, but much of this is not reflected in the standardized test results. Progress has been slow, however, and has not kept pace with his classmates. I feel that in the past few months, [claimant] has become increasingly frustrated by his inability to keep up with the academic tasks of the classroom.

[Claimant] generally gets along well with the other students in the classroom and enjoys some of the classroom activities such as hands-on science experiments, computer lab, library period, etc.

Reading ability has improved for [claimant] with increased accuracy in oral reading, but he continues to have difficulty understanding what he has read.

46. November 22, 1994 San Mateo County SELPA Speech and Language Individualized Education Program (IEP). While still attending CAS, claimant’s mother referred him to the district “for a speech and language evaluation because of language processing difficulties. (See Factual Finding 11).

Claimant began attending an SDC at Brittan Acres School in the San Carlos School District during his fifth grade year (1995-1996), with speech and language services. He was found eligible for special education based on “learning disabilities.”

Claimant began attending Sequoia High School in Redwood City in his ninth grade (1999-2000) year. His placement was in an SDC and he remained eligible for special education based on SLD.

47. February 27, 2001 Sequoia High School Present Levels of Performance. At the start of claimant’s sophomore year he entered the high school “Peninsula Academy” where he carried a full load of Academy classes and two study skills periods with a resource specialist.

He also played football on the school's frosh/soph team. Claimant "struggled with the mainstream curriculum. Even with two study skills periods and hours of work at home with his parents, [claimant] was unable to keep up with the workload, in part because of the independent study skills required. [Claimant] needed one-on-one supervision and direction to initiate and focus on required tasks. In each class, his teachers reported lack of focus, a drifting of attention, lack of consistent effort. Socially [claimant] was the center of some rude and demeaning put-downs by fellow students." The following was reported:

After consultation with his teachers, [claimant's] schedule was modified. He continued in computer class with the Academy and in mainstream world studies and P.E. The balance of his classes were in the resource specialist program. . .

It soon became apparent that this arrangement was not working and claimant refused to attend school many days. He preferred his former SDC classroom and frequently visited there when in school. At the beginning of the second semester of the school year, [claimant's] schedule included two periods of SDC classes with his former SDC teacher, RSP study skills, math, science and world studies, and one mainstream class, foods. [Claimant] seemed to enjoy his SDC classes but reluctantly attended school. The situation has now deteriorated to such an extent that [claimant] is not attending school. The IEP team is being asked to consider returning [claimant] to SDC placement as the least restrictive environment which will serve both his academic and social needs.

[Claimant's] inability to focus and hold focus in both social and academic situations has been a major handicap. He has difficulty learning from social experiences although there has been significant progress over the past year. Academically, [claimant] appears unable to retain data and concepts and is unable to use reason to solve problems with consistency. . .

48. Claimant returned to an SDC placement at Sequoia High School.

49. May 15, 2002 San Mateo County SELPA IEP. The IEP indicated that claimant remained eligible for special education as an individual with a Specific Learning Disability (SLD) during his eleventh grade year (2001-2002).

50. Claimant graduated high school in June 2003. As part of his IEP transition planning, it was determined that claimant should apply to the Department of Rehabilitation and "GGRC."¹⁷

¹⁷ Claimant's parents stated that they did not understand until years later that GGRC

CALIFORNIA DEPARTMENT OF REHABILITATION (DOR)

51. Claimant applied for vocational rehabilitation services with DOR on February 28, 2003. On September 24, 2003, he received a Significance of Disability Determination of Category 1, Most Significant. Applicants receive vocational rehabilitation services based on their priority category. It was determined that claimant, though unimpaired in mobility and self-care, was impaired in work skills, communication, interpersonal skills and work tolerance. He was found to qualify for services, which were anticipated to last two years.

52. Claimant participated in a variety of programs offered by the DOR. The Dreamcatcher program was one designed to help him develop job skills, and offered assistance in finding a job. Claimant was not successful in obtaining paid employment. After approximately 11 years, his case was closed as "other than rehabilitated."

TESTIMONY

53. Todd Payne, Psy.D. is an NBRC Clinical Psychologist with extensive experience assessing and diagnosing individuals with developmental disabilities. Dr. Payne testified that, in his capacity as an NBRC staff psychologist, one of his responsibilities is participating in the intake and eligibility review process. He was a member of claimant's Eligibility Review Team, during both applications for services.

Dr. Payne testified that having adaptive impairments does not establish that an individual has a qualifying disability making him eligible for regional center services and supports. Adaptive deficits can exist without a developmental disability. They must be attributable to one of the five eligible conditions. NBRC concluded that the evidence failed to establish regional center eligibility prior to age 18. Although claimant had deficits in adaptive skills, he did not have an eligible condition causing those deficits.

Dr. Payne opined that the family is seeking eligibility based upon a contention that claimant's condition is closely related to a development disability, ASD, ID or fifth category, because of the impairments under which he struggles. He testified that the evidence did not demonstrate an ASD or intellectual functioning at the level of or similar to ID prior to age 18. Through claimant's entire school career, those disabilities were never diagnosed, and he suggested that claimant's regression in adaptive skills resulted from another source. To have a condition which requires treatment similar to that required by an individual with ID is not simply determining whether the services provided to such persons would benefit claimant. It is whether claimant's condition requires such treatment.

54. John Osner M.Ed., is a Learning Specialist and Mentor at Charles Armstrong School (CAS). He was previously a teacher at the school for 26 years and claimant was a

referred to the Golden Gate Regional Center. They lived within the GGRC catchment area when claimant was in high school.

student in his fourth grade class. Mr. Osner was part of a team that discussed the appropriateness of claimant's placement at CAS. The CAS team ultimately concluded "his learning issues and inability to connect socially meant that the school would not be able to accept him for the following school year." Mr. Osner explained:

Claimant "was a likeable child in my classroom, but was unable to cope with what is expected of a 4th grade student. Even with the adapted curriculum at Charles Armstrong, [claimant] was unable to approach the academic skills of his peers and he appeared to become increasingly frustrated with this as the year progressed. Reviewing his records from the time he spent in my classroom it is notable that, unlike his peers in the classroom, [claimant's] scores on standardized testing in reading and math did not show improvement over the year that he was in my class. Perhaps even more important, he was not developing social maturity and was unable to read many of the social cues from his classmates. He did not know how to connect with other students and this made his classroom experience difficult."

Mr. Osner stated that he did some individual tutoring with claimant the following year "working on basic life skills, math such as counting money and reading a clock. Although we seemed to make some progress in the sessions, when I would return for another session, there was generally very limited or no retention of the skills he had learned in the previous session."

55. Dr. Gasperoni testified to his experience working with claimant for approximately two years as his psychotherapist. He reiterated concerns with claimant's adaptive functioning and limited interests, "video games and comic books." He opined that claimant is substantially impaired in his cognitive and social functioning as evidenced by his impaired adaptive skills as well as his inability to retain information, progress academically, have abstract thoughts, profit from experience, and have meaningful insight into his experiences. Dr. Gasperoni reviewed standardized intelligence and adaptive functioning assessments performed by the other clinicians and, in conjunction with his knowledge and insight working with claimant, determined that he was moderately to severely intellectually disabled with ASD Generalized Anxiety Disorder and Persistent Depressive Disorder. He opined that testing psychologists only see a client briefly and he had the benefit of observing claimant's functioning from more than one perspective.

Dr. Gasperoni suggested that the DSM-5 has removed the IQ cutoff from the diagnostic criteria for an Intellectual Disability and placed more emphasis on adaptive functioning to determine both the existence and severity of an ID. He believed claimant's actual functioning is comparable to that of individuals with a lower IQ score than claimant's. He also suggested that claimant's higher subtest scores on his standardized IQ testing were inflated due to the training he has received throughout his life.

56. Claimant's mother testified to the adaptive difficulties claimant has had throughout his life. She explained her concerns from birth to present and specifically compiled a "Parent Report of Current Adaptive Functioning showing lack of judgment or ability to have insight, profit from experience, and adapt to new situations." She also provided a several page document describing claimant's adaptive skills over time. She reported that as a three-year-old claimant attempted to participate in two preschool programs. She was asked to withdraw him from the first program due to aggressive behavior, and from the second because he was not fully toilet trained. Claimant continued to wet the bed most nights until he was 12.

During his school years, he had trouble with his speech and learning, and making friends was difficult. He can be rough with animals, invades people's personal space and will touch them to get attention. He is unable to read an analog clock and has poor money management skills. He cannot count money and can be taken advantage of when receiving change back from a purchase. He is only interested in having conversations about his own interest, primarily video games, television or comic books. He cannot manage medications and can be overwhelmed by crowds or strangers.

Claimant's mother testified that she turned to Dr. Perry in her desire for clarification. She wanted to understand whether claimant's "condition was ID, ASD, or what, and what the next steps might be." She believed that claimant qualifies for regional center services, requires help getting a job, and needs a caseworker to help with housing, paying bills, and community integration. She believes he functions similar to an individual with ID and could benefit from services offered by the regional center.

57. Eric Tymstra, claimant's cousin, testified to his experiences growing up with claimant. Mr. Tymstra and his twin brother were younger cousins and would play with claimant at family gatherings. This usually involved video games or television. He reported recognizing at an early age that claimant "didn't seem like the older cousin anymore." A big difference developed between interests and conversations. Besides general pleasantries, claimant's conversation was mostly limited to video games and reiterating TV shows.

Mr. Tymstra voiced concern over claimant's inability to live on his own, as well as concerns for his safety. "He has disabilities, doesn't have a job, and is someone who's going to need help the rest of his life." He suggested that claimant is "functioning at the level of early to mid teens."

58. Jeanne Tymstra, claimant's aunt, also testified. She reiterated many of the difficulties claimant has had over the years and opined that he would need help with a "supported job and supported housing." Specifically, he requires assistance "finding employment in a sheltered environment and a living arrangement where he knows who would be there and what he's going to do."

59. Claimant's father testified to recognizing that claimant had "delays when he started talking." In his preschool years he was "all over the place, wound up and too difficult for the preschool." In kindergarten, claimant was "too hyperactive to deal with, to work with"

and it was recommended that he transfer to the SDC. It did not appear that he was making progress at The Charles Armstrong School, and he returned to public school. Claimant's father opined that trying the Academy program during his second year in high school was a "serious mistake, the bullying was extreme."

His father provides claimant with \$40 per month allowance which he is unable to wisely manage. He now has a debit card with a limit that prevents him from continually overdrawing his account.

Claimant's father concluded that claimant "has a developmental disability, is intellectually challenged. I don't know if autism comes closer to explaining him." He believes claimant requires assistance and support to live independently.

60. Dr. Perry testified that the severities of claimant's functional impairments are due to "severe impairment in the executive functions which are now recognized as an important part of cognitive¹⁸/intellectual functioning." She suggested that claimant's greatest areas of impairment, reading comprehension, abstract thinking, and working memory, are all cognitive deficits consistent with executive functioning impairment and they all emerged as looking worse the older claimant became. She opined that due to impairments in executive function, claimant is unable to carry out virtually any of the skills required for adult life. She stated that while claimant has an intellectual disorder that did not reach the numerical IQ to automatically qualify as ID under the DSM-IV during his developmental period, with the introduction of the DSM-5 relying less on IQ score in favor of adaptive deficits, Dr. Gasperoni was correct in diagnosing claimant with an Intellectual Disability, Moderate to Severe. She, along with claimant's mother, did not believe he has an ASD.

Dr. Perry testified that claimant's impaired adaptive functioning and academic deficits are not the result of a learning disorder but rather a result of his deficits in intellectual functioning. She opined that an SLD might "impact academic functioning skills but not a complete failure to live an adult life." She believes claimant's higher IQ subtest scores were the "result of the type of family he was from and the fund of information he has been enriched with by his parents."

Dr. Perry believes claimant was "demonstrating levels of disability and need consistent with consumers of Regional Center services, many of whom are routinely provided job coaching, job coaches and sheltered workshops. Repetition, hands-on training, and strategies like visual cues must be employed to compensate for his poor working memory."

Eligibility Based on Autism

61. DSM-IV-TR section 299.00, Autistic Disorder, states:

¹⁸ The term "cognitive" is defined as "the ability to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience." (Cal. Code Regs, tit. 17, § 54000).

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 . . . Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities.

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 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.

62. DSM-V section 299.00, Autism Spectrum Disorder, states:

The essential features of Autism Spectrum Disorder are persistent impairment in reciprocal social communication and social interaction (Criterion A), and restricted, repetitive patterns of behavior, interests or activities (Criterion B). These symptoms must be present in early childhood and limit or impair everyday functioning. (Criterion C and D). . . The impairments in communication and social interaction specified in Criterion A are pervasive and sustained . . . Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term *spectrum*. Autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

To diagnose Autism Spectrum Disorder, it must be determined that an individual has persistent deficits in social

communication and social interaction across multiple contexts, as manifested by the following, currently or by history: (1) deficits in social-emotional reciprocity, (2) deficits in nonverbal communication behaviors used for social interaction, and (3) deficits in developing, maintaining, and understanding relationships. The individual must also have restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history: (1) stereotyped or repetitive motor movement, use of objects or speech, (2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior, (3) highly restricted, fixated interests that are abnormal in intensity or focus, and/or (4) hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment. In addition, symptoms must be present in the early developmental period and must cause clinically significant impairment in social, occupational, or other important areas of current functioning.

63. Claimant was not diagnosed with autism prior to age 18. Dr. Evered's conclusion that claimant at age 24 had Asperger's disorder was not persuasive. Dr. Evered did not complete a "best practices" assessment and, in fact no standardized testing was administered. He appeared to rely on his conclusion that "daily functioning was judged consistent with Asperger's disorder." Throughout claimant's numerous evaluations and school history, there was no diagnosis of ASD. Though claimant exhibits some autistic-like behaviors, the evidence presented at hearing did not establish that claimant met the threshold requirements to be diagnosed with ASD. Consequently, claimant does not qualify for regional center services under the category of autism.

Eligibility Based on Intellectual Disability

64. 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.

65. 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 functioning¹⁹ in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

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

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

317 Mild Mental Retardation: IQ level 50-55 to approximately 70

¹⁹ 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.”

- 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

66. The Diagnostic Criteria for Intellectual Disability in the DSM-V²⁰ 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.
- C. Onset of intellectual adaptive deficits during the developmental period.

67. 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.

²⁰ The DSM-IV-TR governed during claimant's developmental period. The DSM-5 is the current standard for diagnosis and classification. Testimony presented addressed both versions.

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.

68. Claimant was not diagnosed with an intellectual disability prior to age 18. No evaluators gave a DSM-IV Axis II diagnosis,²¹ and claimant’s lowest reported FSIQ, which was an outlier, was 74 reported by Dr. Young when claimant was 27 years old. It is generally considered that an individual may score lower than his ability but would be unable to score above his ability. At age 17, his FSIQ was reported as 82, which was consistent with other reported scores.

While the DSM-5 does not rely on IQ scores alone, it does require clinical assessment *and* standardized testing of both intellectual and adaptive functioning. While the essential feature per DSM-IV is “significantly subaverage general intellectual functioning,” the DSM-V looks to “deficits in general mental abilities.” And, “intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence.”

²¹ Mental Retardation is reported on Axis II of the DSM-IV.

Dr. Gasperoni's conclusion that claimant is moderately to severely intellectually disabled was not supported by the evidence. That would suggest that the standardized testing equivalent would be an IQ range from approximately 20-25 to 50-55. It appears that he is basing that decision solely on claimant's severe adaptive deficits, but they must be related to deficits in general mental abilities.

Claimant does have significant limitations in adaptive skills, which is complicated by the fact that he appears to be regressing as he ages. Claimant is 30 years old. The evidence presented at hearing did not establish that claimant, within the developmental period, presented with the necessary global deficits confirmed by both clinical assessment and standardized intelligence to support a diagnosis of intellectual disability. Consequently, claimant does not qualify for regional center services under the category of intellectual disability.

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)

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

...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.

70. An 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. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation or 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.

71. Claimant’s presentation is extremely complex. The evidence was overwhelming that he has a substantially disabling condition. He has exhibited behaviors and adaptive functioning deficits since a young age. Mr. Oster’s testimony was persuasive that claimant never had the intellectual functioning to keep up with his peers. It appears that his deficits were not properly diagnosed or fully addressed during his developmental years.

72. The most probable inference from the evidence is that claimant’s disabling condition and adaptive deficits require treatment similar to that required for individuals with intellectual disability. Evidence established that treatment required for individuals with intellectual disability might include long-term training with steps broken down into small, discrete units taught through repetition. Training to achieve goals would include component skills broken down and taught with step-by-step instruction for maintenance and retention. Witnesses testified that claimant requires step-by-step instruction, close supervision, a high level of prompts, reminders and redirection. He needs information broken into small segments, provided slowly and with repetition. The only way claimant appears to have demonstrated improvement is through supervised step-by-step instruction. He has a poor capacity for self-direction and needs prompting and direction to accomplish tasks. He therefore requires treatment similar to that required for individuals with an intellectual disability. He has significant functional limitations in three or more major life activities. Consequently, he is substantially disabled. There was insufficient evidence to establish that his significant adaptive deficits were due solely to mental health issues or learning disabilities. Accordingly, claimant has a developmental disability as defined by the Lanterman Act and is eligible for services and supports from the regional center.

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 mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation [commonly known as the “fifth category”], but shall not include other handicapping conditions that consist solely physical in nature.

2. 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, is not excluded from eligibility for services.

-3. Claimant established that he is eligible to receive services pursuant to the Lanterman Act because he requires treatment similar to that required for individuals with an intellectual disability. - His appeal should therefore be granted.

ORDER

Claimant’s appeal from the North Bay Regional Center’s denial of eligibility for services is granted. Claimant is eligible for regional center services under the Lanterman Act.

DATED: October 5, 2015

DocuSigned by:

Susan H. Hollingshead

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SUSAN H. HOLLINGSHEAD

Administrative Law Judge

Office of Administrative Hearing

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).)