

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

MARK G.,

Claimant,

vs.

ALTA CALIFORNIA REGIONAL  
CENTER,

Service Agency.

OAH No. 2011010253

**DECISION**

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Sacramento, California, on July 23, 24, 25, and 26, 2012.

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

Marc Hartley, Deputy Yuba County Counsel, represented claimant. Claimant's father and his LPS (Lanterman-Petris-Short) Conservator, Asha Davis, Yuba County Public Guardian, were also present.

Oral and documentary evidence was received. Submission of this matter was deferred pending receipt of closing briefs. Service Agency's Closing Brief and Claimant/Authorized Representative's Closing Brief were submitted on August 20, 2012, and marked respectively as Exhibits 45 and 47. Service Agency's Reply to Claimant's Closing Brief and Claimant/Authorized Representative's Closing Hearing Brief were submitted on August 27, 2012, and marked respectively as Exhibits 46 and 48. The record was closed and the matter submitted for decision on August 27, 2012.

## ISSUE

Was the original determination that claimant was eligible for regional center services clearly erroneous pursuant to Welfare and Institutions Code section 4643.5, subdivision (b)?<sup>1</sup>

## FACTUAL FINDINGS

1. Claimant is a forty-four year old conserved man who was found eligible for regional center services in 1983 based on a diagnosis of “Associated Neurological Handicap due to trauma or physical agent.” Records from Merced Behavioral Health, where claimant currently resides, indicate he has been diagnosed with paranoia, delusional thought processes, mania/mood swings and anxiety. He was also diagnosed with Schizoaffective Disorder in March 2009. Claimant has been residing in a locked mental health facility, Country Villa Merced, since approximately May, 2008. Initially his diagnoses were Bipolar I Disorder, manic severe with psychotic features secondary to traumatic brain injury, and paranoid personality disorder. Sutter-Yuba Mental Health clinicians made these diagnoses as part of an evaluation to determine the appropriateness of an LPS conservatorship (Welf. & Inst. Code, §5350 et seq.)

2. Claimant has been conserved by the Yuba County Public Guardian-Conservator.

3. On January 16, 1983, when claimant was fourteen years old, he sustained a traumatic brain injury (TBI) when, after apparently smoking marijuana and acting on a dare, he was struck by a vehicle while “streaking” back and forth across a highway. He was admitted to Chico Community Hospital (CCH) in a comatose state with “multiple trauma.” CCH records noted severe closed head injury, severe multiple skeletal trauma (left temporal skull fractures, pelvic fractures, right surgical neck humeral fracture, fracture of the left distal femur, fracture of the left tibia and fibula), and left temporal hematoma.

Claimant remained in intensive care in a coma for approximately three and a half weeks. On the Glasgow Coma Scale, which rates the severity of the coma, claimant was found to have sustained moderate to severe head injury. After coming out of the coma, claimant remained in the CCH Rehabilitation Unit until April 1983.

4. On February 9, 1983, CCH Medical Social Worker, Tracy Gross initiated, by telephone, an Inquiry/Referral for services from Far Northern Regional Center (FNRC). The request was received by FNRC Supervising Counselor, David Schneider MSW, who documented the reason for the referral as follows:

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

This youngster suffered severe head injuries and multiple broken bones in recent car accident. Admitted to Chico Comm. Hosp. January 16, 1983. Immediate plan is to place into CCH's Rehab. Unit. Client unable to vocalize. Extent of neurological damage still being evaluated. Hospital social worker making early referral to FNRC for case management services, possible psychometric testing, coordination with public schools, referral for respite care, supportive counseling. Family is aware of referral to FNRC.

Mr. Schneider noted that the matter was assigned to Nancy Cornell MSW, a FNRC Program Coordinator.

5. An undated Social Assessment signed by Mr. Schneider and Ms. Cornell stated that an initial interview was held with claimant's parents at their home on February 15, 1983. The referral was initiated by the Medical Social Worker because "she is interested in securing any available and appropriate services for [claimant], who has suffered excessive injuries and trauma in a recent car accident."

6. On February 24, 1983, FNRC Supervising Counselor, David Schneider attended a CCH "family meeting" which included a hospital interdisciplinary team, claimant's parents, uncle and sister. At that time, claimant's physician indicated that Claimant was medically stable in spite of his injuries. The physical therapist reported that he was not yet walking but was able to stand and bear weight. The occupational therapist was working with claimant on fine and gross motor skills and developing dressing skills. Nutrition was improving as claimant was partially able to feed himself. The speech therapist reported that there were no vocalizations that she hears, but claimant was quite non-cooperative with her. Mother stated that she hears grunts in response to her conversation.

7. A FNRC Core Staff Conference Report dated March 8, 1983, found that claimant had a diagnosis of "Associated Neurological Handicap due to trauma or physical agent" with a substantial handicap that is likely to continue indefinitely. The report noted that major impairments existed in the following areas: Communication Skills, Learning, Self-Care, Mobility, Self-Direction, Capacity for Independent Living, and Economic Self-Sufficiency.

Service Recommendations stated:

1. Screening found eligible for FNRC services.
2. Request counseling funding--deferred--name put on waiting list.
3. Program Coordinator to urge family to apply for S.S.I. promptly.

This report did not indicate that any persons other than Ms. Cornell participated in the "screening" which found claimant "eligible for FNRC services" There was no evidence demonstrating how this decision was made or what assessment data was considered. Claimant was apparently made eligible under the "Fifth Category" of eligibility based on "Associated Neurological Handicap Due to Trauma or Physical Agent," with substantial disabilities in all

seven areas (communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self sufficiency).

8. 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 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 are solely physical in nature.

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

(a) “Developmental Disability” means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Development Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

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

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

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

where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

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

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

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

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

- (1) Self-care.
- (2) Receptive and expressive language.
- (3) Learning.
- (4) Mobility.
- (5) Self-direction.
- (6) Capacity for independent living.
- (7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

11. 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.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

12. Claimant was discharged home from CCH on April 8, 1983.

13. Approximately four months after the accident, a Psycho-Educational Study conducted by Chico Unified School District provided the following results from the Wechsler Intelligence Scale for Children-Revised (WISC-R):

Verbal Scale = 86      Performance Scale = 70      Full Scale Score = 76

	<u>SS</u>		<u>SS</u>
Information	9	Picture Completion	5
Similarities	7	Picture Arrangement	4
Arithmetic	8	Block Design	10
Vocabulary	8	Object Assembly	7
Comprehension	7	Coding	1
Digit Span	12		

The assessor noted that the results of the WISC-R “must be interpreted with caution due to [claimant’s] current limitations – specifically, language facility and limited use of his right arm.” “Examination of the Verbal Scale indicates rather consistent functioning (low average to average) with the exception of short term auditory memory for digits (high average). The Performance Scale subtests were exceptionally variable. Extremely poor performance (first percentile) on the Coding Subtest was largely due to the limited arm/hand use.” He also believed that “limited ability to use two hands for manipulation of the test pieces impaired [claimant’s] functioning” on the Block Design and Object Assembly Subtests.

ACRC Staff Psychologist Cynthia Root testified that these results indicate that claimant’s intellectual function so soon after the accident was approximately in the low average range.

Appraisal of claimant’s “self-help and vocational skills” as reported by his parents, included the following:

[Claimant] is able to prepare simple meals and do simple chores around the house. He can make phone calls, put himself to bed, and walk around the house unaided; except for the evenings when he is tired. He cannot shower completely alone nor dry himself. He needs a shower chair and cannot get in and out of the tub by himself. We are able to leave him alone for a few hours in the house with confidence. He is able to dress himself – sometimes he has trouble with his left shoe and sock because of his physical limitations.

14. A subsequent FNRC Core Staff Conference Report, dated March 21, 1984, continued to find claimant eligible for regional center services based on “Associated Neurological Handicap.” However, it was noted that major impairments no longer existed in Communication Skills, Self-Care or Mobility.

15. A FNRC Core Staff Conference Report, dated May 15, 1984, stated that major impairments only existed in Self-Direction and Capacity for Independent Living.

16. A FNRC Core Staff Report, dated July 17, 1984, continued to find claimant eligible for regional center services based on Associated Neurological Handicap and added Economic Self-Sufficiency as an existing major impairment. No major impairments were noted in a July 24, 1984 Report which confirmed eligibility.

17. On January 14, 1985, claimant was referred to Butte County Child Protective Services (Butte CPS) by his parents who sought help for his oppositional and assaultive behaviors. He was placed in foster care on February 27, 1985, and was enrolled in a residential program at Fred Finch Youth Center in Oakland, California on March 18, 1985.

18. In a January 29, 1985 history of Claimant provided by his parents, they expressed that shortly after age seven claimant “began to demonstrate non-compliance at home but not at school. He became increasingly more non-compliant and difficult at home.” At age 12, claimant’s “difficulties increased and he became more aggressive and argumentative [sic]. He became increasingly moody & slothful and gained a lot of weight. He still did well academically. He began regularly scheduled psychological [sic] counseling sessions. When claimant entered Junior High School, it seems he was fighting most of the time, with his peers.”

At age fourteen, “During an argument with his Mother when his Father was not at home, he seriously assaulted her with his fists. This got him involved with the Sheriff’s Department and two days later, while waiting for a call from the Probation Department, he attacked his father with a screwdriver during an argument [sic]. He was taken to Juvenile Hall and consequently released for a period of home probation.”

19. On March 29, 1985, an Intake Summary was completed by Sandra Schindler, MSW, Clinical Social Worker, and signed by Ms. Schindler, Howard Blankfeld, M.D., Medical Director, and Curt Sugiyama, LCSW, Program Director. The Summary contained the following:<sup>2</sup>

DIAGNOSIS

Axis I: 310.10 Organic Personality Syndrome

Axis II: V71.09 No Diagnosis

Axis III: Post Brain trauma, Acne Vulgaris

Axis IV: Psychosocial, Stress-extreme

Axis V: Adaptive level-poor

Note: [Claimant] is fully ambulatory

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<sup>2</sup> The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) is the current standard for diagnosis and classification. 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

The Intake Summary referenced a psychological evaluation given by Randy Haapanen, Ph.D., on December 18, 1984, that found claimant to be functioning within the lower range of average intelligence with a standard score of 91. The recommendation was to “Admit to Fred Finch Youth Center” with an estimated duration of treatment “until his 18<sup>th</sup> birthday.”

20. Licensed Psychologist Randy Haapanen, Ph.D. performed a psychological exam of claimant on December 18, 1984. His January 20, 1985 report noted the following reason for the referral:

[Claimant] has been my client for 9 months on a schedule of 2 times per month as allowed by medi-cal. He has continually had problems at home (including calling the police on his parents) and school and recently had some problems in judgement (exposing himself to several nurses) during a hospital stay for corrective surgery. It was felt by [claimant] and his parents that a more complete psychological evaluation might provide useful information for treatment planning. Since the testing, the parents have wanted to seriously consider out of home placement for [claimant] and this report is being prepared to provide information toward this decision as well.

21. Dr. Haapanen noted that claimant “has had behavioral problems since he was very young. As he got older the problems had escalated into physical confrontations with both parents; on one occasion he was placed in Juvenile Hall. He was seeing a psychologist, Dr. Rauch, for several years from about the age of 13.” In April of 1984 [claimant] indicated he would prefer to talk to a male therapist and began seeing me.”

22. Dr. Haapanen administered the Peabody Picture Vocabulary test – Revised (PPVT-R), Rorschach, Thematic Apperception Test (TAT) and Sentence Completion. He also noted the following recently administered test results:

See test report from Jo Danti, Ph.D., University of California Medical Center, Sacramento, Psychiatry Center (8/6/84):

Wechsler Intelligence Scale for Children – Revised (WISC-R)  
-lower range of average intelligence

Luria Neuropsychological [sic]: expressive language difficulties, low motoric response, “no evidence of neurological dysfunction that would account for his current behavioral difficulties.”

The PPVT-R is a test of vocabulary recognition that Dr. Haapanen states “can be used as a screening instrument for verbal intellectual functioning. [Claimant] obtained a standard score of 91 (28<sup>th</sup>ile) which is consistent with the average to low average performance on the WISC-R

reported in previous testing.” It would not have been appropriate to re-administer the WISC-R only four months after the prior administration.

He then offered the following:

Diagnostic Impression

Axis I	312.21 312.39 293.81	Conduct Disorder: socialized, nonaggressive Atypical impulse control disorder (tentative) Organic Delusional Syndrome
Axis II	V71.09	No diagnosis on Axis II
Axis III		Neurological dysfunction due to brain injury in auto accident
Axis IV		Psychosocial stressor: Divorce of biological parent Severity: 4 – moderate
Axis V		Highest level of adaptive functioning past year: 5 - poor

Dr. Haapanen made no diagnosis on Axis II, which is where a diagnosis regarding intellectual functioning would be placed.

23. An assessment in October, 1983, by the California State University, Chico, Clinical Training Program, had determined that “No specific cognitive disability could be ascertained.”

24. In a February 4, 1985 letter, Psychologist Janet Rauch explained that she had been providing services to claimant and his family since 1980 when claimant’s parents first sought help due to the following:

- Difficulty with peers—tendency towards social isolation because of having few friends.
- Much conflict between [claimant] and his sister, jealousy.
- Unpleasant, pushy, and demanding with parents.
- Unhappy with a chip on his shoulder.

Dr. Rauch noted that “residential treatment seems the last best way to try to help him make changes.”

25. Alfred P. French, M.D. evaluated claimant on October 29, 1985. He noted that claimant had been at the residential treatment facility in Oakland “wherein he had difficulty, including physical altercations with staff. He is now referred in the context of long-term planning, which is becoming urgent due to his age.”

Dr. French addressed claimant's "current psychiatric status" as follows: "He presents the typical history of the "organic personality" with the emotional lability and the sense of confusion when others demand things he cannot do. He has, of course, areas of excellent function and the distinction between "can't" and "won't" is difficult. There is evidence on the MMPI (Minnesota Multiphasic Personality Inventory) of extra-ordinary level of sexual confusion." "The worrisome part of the record is the elevation of the Paranoia and Deviant Scales at 2.5 and 2.3 standard deviations." Results from the Rorschach test indicated that claimant's perceptual accuracy was "clearly in the psychotic range."

Dr. French also suggested that claimant "may be a candidate for medication. Some brain-damaged and, therefore, aggressive individuals do well on Lithium, this is somewhat cumbersome to adjust initially, requiring lab work, but once stabilized is easily used. His cooperation would, of course, be essential."

He also opined that "any placement must realize that he must be approached in a carefully structured way. For example, it might make sense to advise him of infractions in a specifically structured manner, with several staff present so that no one individual is required to confront him."

26. FNRC Core Staff Reports dated December 23, 1985, and April 17, 1986, found claimant continued to be eligible for regional center services and had major impairments in the areas of Self-Direction, Capacity for Independent Living and Economic Self-Sufficiency

27. By letter dated June 18, 1986, FNRC Program Coordinator Carol Oba-Winslow informed ACRC that claimant's case was being transferred to ACRC because he was moving to Lampasas Independent Living Center in Sacramento. Claimant was then eighteen years old. The letter explained that claimant lived with his parents and sister in Chico until a year and half prior to that date when he was made a ward of the court and placed in the Fred Finch Youth Center in Oakland. His "threats and actions of violence, poor judgment and impulsiveness were more than the family could cope with."

28. Section 4643.5, subdivisions (a) and (b) provide:

(a) If a consumer is or has been determined to be eligible for services by a regional center, he or she shall also be considered eligible by any other regional center if he or she has moved to another location within the state.

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

29. By letter dated October 1, 1986, Carol Wilhelm, claimant's ACRC Service Coordinator, contacted ACRC's Associate Director/Chief Counselor, Jim Stevens, to request a rate exception for claimant. She stated that he was a "19 year old male diagnosed as not retarded with neurological disfunction [sic] due to brain injury, conduct disorder (312.21), organic delusional syndrome (293.81) and atypical impulse control disorder (312.39).

In requesting the "intensive rate" Ms. Wilhelm explained that "[claimant] has a long history of verbal aggression, physical aggression and suicidal threats. While residing at Lampasas (date of placement was July, 1986), [claimant] has had numerous episodes of noncompliant behaviors. During the first week, he came home drunk and was observed using drugs. On 9-5-86, he brought home a hooker and when confronted by staff, spent several days in depression threatening suicide and violence."

"[Claimant's] family had him removed from their home in 1985 after several episodes of violence against family members and attempts of suicide. He was placed at the Fred Finch Youth Center in Oakland until June, 1986."

"[Claimant] is requiring close supervision and monitoring due to his many problems. Staff at Lampasas have successfully obtained a number of psychiatric services through the mental health system for [claimant] and he seems to be more stable than he was originally when placed." Ms. Wilhelm opined that "his psychiatric diagnosis and multiple behavioral problems justify the intensive rate."

30. ACRC's Eligibility Review on October 7, 1986, stated that claimant was "eligible for 4 months only—Probably not elig. After that—Not M.R." The eligibility review participants included a physician, psychologist, supervising counselor and claimant's service coordinator, Ms Wilhelm

31. By letter dated October 14, 1986, Ms. Wilhelm notified claimant's parents that she had been requested by Lampasas to locate a new placement for claimant due to his being uncooperative and aggressive. She explained that she was aware that he was on the waiting list for "two Mental Health residential independent living programs" and she would be "looking for a board and care facility near his present location since he has become familiar with that area and can get to and from his programs easily." Ms. Wilhelm also explained that, "due to [claimant's] remarkable recovery from his injuries, he is only eligible for Regional Center services until January, 1987. At that time, our psychologist and physician will want to see how he is progressing and there is a good probability that he will no longer be eligible for our services."

32. By letters dated March 9 and 10, 1987, ACRC informed claimant and his parents that he would no longer be eligible for ACRC services as of March 31, 1987. Claimant had applied to become his own payee for SSI from which he would pay his room and board. Protective Services was notified and Transitional Living and Community Support (TLCS) was

available for assistance. Parker House, claimant's board and care facility, was also made aware of this change.

It appears that claimant was in agreement with this determination. Ms. Wilhelm testified that claimant stated that he was "not mentally retarded and didn't want to be associated with those people." (ACRC consumers).

33. ACRC closed claimant's case on March 31, 1987

34. Claimant subsequently relocated to Butte County and on October 26, 1987, a FNRC Social Assessment was completed after claimant self-referred seeking funding for physical therapy. The Assessment noted that claimant had previously been a regional center client and his case had been closed by ACRC on March 31, 1987, after it was determined that he was no longer eligible for services. Claimant stated that he needed funding for physical therapy because Medi-Cal would not cover it and his physical therapist suggested that he attempt to obtain help through the regional center. Sarah Hazen, MSW, FNRC Hospital Liaison Coordinator concluded as follows:

ASSESSMENT:

[Claimant] is a young man with a history of severe trauma to the brain. Although he has recovered sufficiently that Alta California Regional Center found him ineligible for services, he has ongoing problems as a result of this accident. He has a history of behavior problems which were probably exacerbated by the accident and additional brain damage. I recommend that the Regional Center help [claimant] obtain physical therapy. I also feel that he would make use of ongoing case management services. I do not see any particular barriers to implementation at this time.

Ms. Hazen gave no information as to why claimant would be eligible for FNRC services. FNRC "accepted his case" on October 27, 1987.

35. In 1988, claimant was apparently again made eligible by FNRC based on a diagnosis of "A.N.H." FNRC eligibility reviews continued to find claimant eligible based on determinations including Associated Neurological Handicap, Post-Concussion Syndrome and Closed Head Trauma/Organic Brain Syndrome, with changing areas of substantial disability.

36. In November 1997, FNRC reviewed claimant's edibility and determined that he was not eligible because his "functional deficits appear to be the result of mental health disorder." Staff present for this review included the FNRC Associate Director, as well as a Physician, Nurse, Psychologist, Supervisor and Service Coordinator.

The records were unclear until a FNRC review in 2005 which indicated that claimant had remained eligible for services "due to administrative reconsideration" of the ineligibility decision. Later that year, claimant's case was again transferred to ACRC due to a change of

residence within ACRC's catchment area. He has received services through ACRC since that time.

37. Over the years, claimant has been placed in numerous residential living facilities. He attempted to attend Butte Community College and to work in sheltered work programs. Independent living situations have been discontinued and he has been placed in institutional or community settings after being involuntarily committed to mental health facilities. He has been repeatedly arrested.

38. ACRC referred claimant to Deborah Schmidt, Ph.D. for a psychological evaluation "to assess his intellectual abilities and his adaptive functioning." The evaluation was performed on June 18, 2007, and claimant was seen "behind glass while in the Yuba County Jail." Claimant was administered the Verbal subtests of the Wechsler Adult Intelligence Scale in order to assess intellectual functioning. The performance subtests were not administered, given he was seen behind glass and they were impossible to administer. Dr. Schmidt determined that "claimant obtained a Verbal IQ of 81 and a Verbal Comprehension Index score both of which are in the low average range. His Working Memory Index score is in the borderline range. His IQ scores appear to be valid." His scaled scores for the WAIS-III Verbal subtest are as follows:

Vocabulary	5	Information	8
Similarities	8	Comprehension	7
Arithmetic	5	Letter-Number Sequencing	4
Verbal IQ:		81	
Verbal Comprehension Index Score:		84	
Working Memory Index Score:		73	

Dr. Schmidt administered the reading subtest of the Wide Range Achievement Test-3 (WRAT-3) in order to assess reading ability. Claimant's "test results suggest that he is reading at the post high school level, which places him in the 69<sup>th</sup> percentile for adults in his age group."

She also administered the Vineland Adaptive Behavior Scales, in order to assess adaptive functioning, with the following results:

Test results suggest that he is functioning at a moderately low to adequate adaptive level between the age equivalents of 13 years, 3 months to 18 years, 11 months. He obtained an Adaptive Behavior Composite scaled score of 80, which places him in the 9<sup>th</sup> percentile for adults in his age group. His overall adaptive functioning is considered to be moderately low. On the Communication Domain, he obtained a scaled score of 78, which places him in the 7<sup>th</sup> percentile for adults in his age group. His adaptive level is moderately low, and he is functioning at an age equivalent of 13 years, 3 months. On the Daily Living Skills

Domain, he obtained a standard score of 106, which places him in the 65<sup>th</sup> percentile for adults in his age group. His adaptive level in this area is considered to be adequate, and he is functioning at an adaptive level of 18 years, 11 months. On the Socialization Domain, he obtained a standard score of 72, which places him in the 3<sup>rd</sup> percentile for adults in his age group. His adaptive level in this area is considered to be moderately low, and he is functioning at an age equivalent of 13 years, 8 months.

The results of the Vineland were based on claimants self-report and the accuracy is therefore in question. It would be likely that claimant's adaptive functioning is in a lower range than reported based on all available evidence.

In the clinical interview, Dr. Schmidt noted that claimant tended to be a "poor reporter." He "gave a confusing explanation as to why he was in jail. He stated that apparently the individuals in his care home were afraid of him, but he denied threatening anyone, as has been alleged. He believes that there is some type of conspiracy involved between the female who managed the care home, whom he believes was sexually harassing him, and his attorney. His thinking at this point appears to be psychotic." When asked why he was living in a care home, "he replied that he is not really sure, but it has something to do with being beaten up by the Marysville Police Department." He reported that he graduated from California State University, Chico with a bachelor's degree in psychology and fine arts, and then obtained a Master's degree in psychology from the same university. He explained that he is licensed as an art therapist in Shasta County. He also relayed several stories about the woman who manages his care home "hitting on him" sexually. None of this information appeared to be accurate.

39. In 2010, claimant sought to terminate his conservatorship. ACRC stated that while completing a letter in support for the LPS conservatorship, claimant's diagnosis and psychological evaluation were reviewed. Janice Bonner, claimant's ACRC Service Coordinator, testified that the review caused her to question the basis for claimant's regional center eligibility. Specifically, she became aware of documents in claimant's chart stating that he was ineligible and she found it unclear under what diagnosis he was eligible for regional center services.

Ms. Bonner described claimant as "very articulate, interesting, friendly, descriptive who writes narratives using good spelling." She testified that medication management has been a concern because claimant does not like to take his medications. Ms. Bonner reported that claimant often seemed delusional and paranoid. He reported to her that people were stealing millions of dollars from him, he has many advanced degrees, is a priest, a medical doctor, is in various branches of the military, people are stealing his identity and his name is "Cletus." He told her that he shouldn't be conserved or living in a psychiatric facility.

Therefore, Ms. Bonner requested that ACRC Staff Psychologist Cynthia Root, Ph.D. review claimant's chart to determine his eligibility for regional center services.

Ms. Bonner corresponded by email and telephone with Dr. Leonard Magnani (ACRC's Medical Director, a physician), Dr. Phyllis Magnani, ACRC Staff Psychologist and Dr. Root.

40. Dr. Root testified that, after reviewing all the available information, she made a preliminary determination that claimant might not be eligible for regional center services. The matter was then referred to ACRC's Best Practice Committee.

The team consisting of ACRC's Chief Counselor David Rydquist, ACRC Director of Clinical and Intake Services Ron Huff, Ph.D.,(a Psychologist), Dr. Root, Ms. Bonner and her Supervising Counselor, Terry Rhoades, met telephonically on April 20, 2010 and determined that claimant does not have a developmental disability and therefore is not eligible for regional center services. The team concluded that claimant had low average to average intelligence and did not have a condition closely related to mental retardation or requiring treatment similar to that required by individuals with mental retardation

41. ACRC contends that it spent several months working with claimant, his LPS Conservator (Yuba County Public Guardian) and Sutter Yuba Mental Health Services (SYMHS) to ensure that claimant would continue to receive the services and supports he needed if ACRC eligibility and services were terminated.

42. Claimant's representative contends that ACRC sought assistance from SYMHS to secure placement for claimant with the understanding that ACRC would bear the financial burden for the placement. Once SYMHS had secured the placement, "ACRC preemptively and unilaterally" determined that claimant was no longer eligible for regional center services and that past decisions granting eligibility were "clearly erroneous."

43. As a result of the eligibility team determination, A Notice of Proposed Action (NOPA) was issued on December 1, 2010, informing claimant that ACRC determined he is not eligible for regional center services. The NOPA stated:

Reason for action: On 4/20/2010, the ACRC Interdisciplinary Team composed of Staff Psychologist, Cynthia Root, Ph.D., Director of Clinical Services Ron Huff, Ph.D. and Services Coordinator Janice Bonner, BA, conducted a comprehensive reassessment of [claimant's] regional center eligibility, and reviewed all of the information and records in its possession, including but not limited to: ACRC Intake Assessment, 3/29/1985, by Sandra Schindler, MSW; Psychiatric Evaluation, 11/1/1985, by Alfred French, MD; Psychological Evaluation, 6/19/2007, By Debra Schmidt, Ph.D; Progress Notes, 4/4/2007, By Hari Goyal, MD; Psychiatric Progress Notes, 7/22/2008, from Merced Behavioral Health; Physicians orders, 3/4/2009. Based on all the information in ACRC's possession, the Team determined that [claimant] does not have Mental Retardation, Autistic Disorder, Cerebral Palsy or Epilepsy. The Team also found that

[claimant] does not have a condition closely related to mental retardation nor one that requires treatment similar to that required for individuals with mental retardation. [Claimant] suffers solely from a psychiatric disorder, which is a condition excluded from the statutory definition of “developmental disability.” [Claimant] is conserved under an LPS conservatorship for being gravely disabled due to a mental disorder and has been successfully placed in a mental health facility since July 2008. [Claimant] was diagnosed with Bipolar Disorder in 7/2008, but was later diagnosed with Schizoaffective Disorder in 3/2009, according to the charts from Merced Behavioral Health where [claimant] resides. It was also noted in the records that [claimant] has paranoia, delusional thought processes, mania/mood swings and anxiety. As a result of this comprehensive reassessment, ACRC has determined that [claimant] does not have a developmental disability, and that the original finding that [claimant] was eligible for regional center services was therefore clearly erroneous.

44. On December 6, 2010, claimant filed a Fair Hearing Request, disputing his ineligibility for services and seeking “continuation of services and benefits.”

45. An Informal Meeting was held on February 15, 2011 with the following persons present:

Claimant  
Asha Davis, Yuba County Public Guardian, LPS Guardian  
Jackie Coleman, Client Rights Advocate  
Adam Reeb, Transportation  
Tom Sherry, MFT, Director, Yuba Sutter Mental Health  
Maura Quinn-Brisano, MFT, Yuba Sutter Mental Health  
Ron Hayman, M.D., Chief Psychiatrist, Yuba Sutter Mental Health  
Linda Loos, Ph.D., Program Manager, Yuba Sutter Mental Health  
Hardeep Cloty, Yuba Sutter Mental Health  
Phyllis Magnani, Ph.D., ACRC Staff Psychologist  
Janice Bonner, ACRC Service Coordinator  
Terry Rhoades, ACRC Supervising Counselor  
Robin Black, ACRC Legal Services Specialist and Designee of ACRC Executive Director

The record in the Informal Meeting was held open pending further review of medical records and receipt of additional records. After a review of all the relevant documentation, as well as consideration of the information provided at the Informal Meeting, the Hearing Designee’s Informal Meeting Decision dated June 10, 2011, found “ACRC’s decision that [claimant] is not eligible for regional center services is hereby UPHELD.”

46. Because claimant was previously determined to have a disability that made him eligible for regional center services, section 4643.5, subdivision (b) applies as follows:

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

ACRC has the burden of proof of establishing that the original determination that claimant has a developmental disability is “clearly erroneous.”

47. ACRC’s Medical Director, Dr. Leonard Magnani M.D., reviewed claimant’s records to ascertain whether the determination that he was developmentally disabled was clearly erroneous. Dr. Magnani retired in spring, 2012. Dr. Terrance Wardinsky M.D. testified that he reviewed this matter with Dr. Magnani and personally reviewed “voluminous records; eight boxes on a gurney.” Dr. Wardinsky is an ACRC Consulting Physician with extensive experience including many years as the ACRC Medical Director. Neither physician found organic brain damage to constitute a developmental disability. No evidence of seizures prior to age eighteen was found so they concluded that he could not be found eligible for regional center services based on epilepsy.

ACRC’s Medical Director, Dr. Leonard Magnani performed a thorough review of claimant’s medical records and concluded as follows:

From my perspective, the “cause” of mental illness is not addresses [sic] by Lanterman. It’s hard to imagine that the very rare cases of childhood schizophrenia or bipolar disorder with psychotic features do not all have neuroanatomical (i.e. structural) causes. There is no literature that argues if a structural brain anomaly or pathologic morphology exists, then a mental disorder diagnosis can not be made. The fact remains that if the mental illness were removed from this consumer, he would not be applying for ACRC services. Hence, the major impairments in three areas are “solely due” to mental illness and we can not make [claimant] eligible without breaking the law.

48. Dr. Wardinsky testified that TBI is not, in and of itself a developmental disability. An individual with a TBI may qualify for regional center services, typically fifth category, if the individual meets the qualifying conditions. He testified that it was too early for FNRC to have made that determination in claimant’s case. It could not be determined how the TBI would affect him. The agency would “need to understand the rehabilitation/recovery. How has the TBI affected him permanently and substantially?” Claimant was rehabilitating and records show he made “substantial progress.”

49. Maura Quinn-Briseno, MFT, Clinical Supervisor Psychiatric Emergency Services, Sutter-Yuba Mental Health Services, recommended by letter dated February 6, 2008, to the Yuba County District Attorney, that ACRC “pursue a 6500 Conservatorship of [claimant] due to his history of chronic medical noncompliance, threatening and assaultive behaviors making voluntary placement impossible. He has been noncompliant with psychotropic medications since November or December 2006. [Claimant] is being evicted from Sunrise Gardens board and care where he most recently resided since June 2007. The eviction is a result of unmanageable behaviors. The most recent of which occurred 1/18/08 when he took over the board and care office, refused to allow staff to make or receive calls, impersonated the owner and a medical doctor in his answering of the facility call and eventually became assaultive when someone attempted to move him.”

50. Ms. Quinn-Briseno explained that “SYMHS first contact with [claimant] was when he was admitted to the inpatient psychiatric facility January 19, 2006 through March 3, 2006. He had become agitated, highly delusional and hypersexual at Emmanuel skilled nursing after refusing antipsychotic and mood stabilizing medications prescribed by his primary care physician (PCP). [Claimant] was convalescing at Emmanuel SNF since shortly after his arrest by Marysville Police for ‘assault with a deadly weapon and felony resisting arrest’ charges. During his arrest the police reportedly required use of several taser darts and batons to subdue [claimant] incurring several fractures to [claimant’s] extremities. During [claimant’s] 45-day psychiatric hospitalization he exhibited paranoid and grandiose delusions, was sexually preoccupied with erotomanic themes involving mental health staff and was easily agitated. He refused all psychotropic medications until a Sutter County Superior Court REISE Hearing determined he lacked capacity to determine need for medications and the court ordered medications could be given involuntarily. In the last week of his 45-day inpatient episode he continued to express delusions about specific staff members and expressed specific threats to assault a particular nurse on several occasions, even disclosing a premeditated intent of when and how he would do it.”

“Earliest psychiatric treatment records available to [SYMHS] indicate treatment by Tehama County Mental Health August 2004 through at least May of 2005 with diagnosis of: Psychosis Due to Head Trauma (DSM-IV-TR 293.8) and Personality Change Due to Head Trauma (DSM-IV-TR 310.1). Tehama County Mental Health records indicate homicidal ideation as a problem they were addressing. Parents report [claimant] received counseling services prior to the accident for severe mood swings and possible diagnosis of Bipolar Disorder.”

“Claimant’s current diagnosis is Mood Disorder Due to General Medical Condition, Traumatic Brain Injury (TBI) with Mixed Features and Personality Change secondary to TBI. He was previously diagnosed Bipolar Disorder Manic Episode, Severe with Psychotic Features secondary to brain injury.”

51. Ronald Hayman, M.D., has been a Sutter Yuba Mental Health psychiatrist for fifty-two years. SYMHS requested that he examine claimant in light of the outstanding issues with ACRC and an examination was conducted on April 24, 2012. Dr. Hayman’s report noted

that the “question is concerning mental retardation.” He stated that “after reviewing records since 1983” claimant “fails” in all areas of adaptive functioning. Dr. Hayman concluded as follows:

Axis I:	317	Mild Mental Retardation
Axis II:	293.9	Mental Disorder NOS Due to Severe Brain Damage to Frontal, Parietal, Temporal Lobes and Some Encephalomalacia of Fiber Tracks, R/O Mental Disorder NOS Due to Childhood Use of Cannabis
Axis III:		Brain damage to frontal, parietal, temporal lobes and some encephalomalacia of fiber tracks
Axis IV:		Family, legal system, Seizure Disorder, dysfunctional personal relationships, and educational abilities
Axis V:		Current GAF = 39

52. Dr. Hayman testified that claimant “made a remarkable recovery from his accident, in many ways”, but has “severe limitations in adaptive functioning.” When discussing the DSM-IV-TR requirements for mental retardation, he testified that “he’s a contrarian in this field’ but contends that “IQ is not accurate with brain injury.” He then explained that he made a mistake in claimant’s Axis I diagnosis and it should have been “Moderate Mental Retardation.” He also opined that the “diagnosis might change with treatment.”

When questioned about this diagnosis he stated that he gave the diagnoses on the basis of adaptive functioning. He is not a psychologist and did not administer any IQ testing. He also concluded that claimant has a condition similar to mental retardation stating that “with his alleged IQ, why isn’t claimant adapting better?”

Dr Hayman’s report includes the following:

The reason for his multiple diagnostic labels and his plethora of medications of which perhaps Depakote and/or Dilantin have helped his seizure activity is due primarily to the fact that the diagnostic considerations avoided what is his obvious diagnosis. He suffers from frontal lobe syndrome. He has had three MRIs, last in 2011, all showing severe encephalomalacia including right frontal lobe, left temporal lobe, left parietal lobe with gliotic changes and some encephalomalacia of some fiber tracks. As you are aware frontal lobe syndrome has been recognized since the late 1950s; however, for whatever reasons the pathologic conditions caused by frontal lobe, temporal lobe, parietal lobe encephalomalacia often goes unnoticed clinically and indeed the relevance to understanding of brain behavior relationships have been neglected. Detection can be very difficult with tradition [sic] neurological testing since frontal lobe disorders affect only elements of the person’s behavior differing from tradition

neurologic syndromes. Also, the complication is that these behaviors may fluctuate from one test date to another. Therefore standard neurological exams will often be normal as may results of psychological tests such as the Wechsler Adult Intelligence Scale that he had, as well as the Wechsler Children's Test.

(Emphasis in Original).

53. Dr. Hayman questioned whether “treatment similar to that required for individuals with mental retardation” had been offered to claimant and how he responded to it. He contends that “mental health treatment doesn't help and the regional center can provide training which is what claimant really needs instead of therapy which isn't helping.” When ACRC questioned what training he was referring to, he stated that he “did not know what services the regional center provides; I don't have much contact with them,” he did suggest “neuroplasticity which is a treatment that is now available. The concept is that neurons that fire together wire together. You hope therefore you can retrain circuits so that people can relearn. Because no DTI imaging was done we do not know what shape his remaining white fiber tracks are in.” He believes that this treatment may be offered through UCSF.

54. Dr. Hayman opined that claimant's behaviors may not be psychiatric but may be due to orbital-frontal lesion which was shown on MRI. He believes an individual with this type of lesion could present with symptoms which mimic those exhibited by persons having certain psychiatric conditions such as schizophrenia, schizoaffective disorder, or disorders where delusional thinking or hallucinations are common. Individuals with frontal lobe damage would present with behaviors similar to mental illness yet not be a psychiatric problem. Since MRIs were not available until more recently, we don't have an earlier version of what claimant's brain looked like. He also argued that ACRC should have ordered an MRI prior to determining that claimant was ineligible for regional center services.

55. A November 4, 2004, CT scan of the brain showed the following as reported by Jack R. Kure, M.D.:

**FINDINGS:**

No prior studies are available at this facility for comparison. There is irregular focal decreased attenuation suggestive of atrophy and encephalomalacia in the left parietal cortex and deep white matter just posterolateral to the temporal horn of the lateral ventricle. No associated mass effect or contrast enhancement are seen.

**IMPRESSION:**

Focal cortical atrophy/encephalomalacia in the mid to posterior portion of the left parietal lobe adjacent to the temporal horn of

the left lateral ventricle. There may be some minimal cortical and white matter atrophy in the right frontal/parietal cortex. No other focal or acute intracranial abnormalities are seen. Comparison with prior studies, if any are available, would be helpful.

56. A brain MRI was subsequently recommended and the imaging was conducted on October 31, 2011. Interpreting Radiologist Serge Djukic, M.D. found the following:

**IMPRESSION:**

1. Prominent extraaxial spaces, far more than expected for age.
2. Right frontal, and left temporal lobe areas of encephalomalacia with Gliosis. This could be related to previous infarctions, or previous Infection/inflammation, post traumatic, etc. Recommend clinical correlation. Again, this is somewhat unusual for age.
3. Prominent sinus disease as discussed above.
4. No evidence for acute cerebral infarction, intracranial mass or extraaxial collections.

57. Bradford Luz, Ph.D., is a Psychologist and Assistant Director of Human Services for Sutter-Yuba Mental Health Services. He explained the scope of neuropsychology emphasizing the focus on the cause of behavior and how it relates to functions in the brain.

Dr. Luz reviewed claimant's psychological and medical records and offered his insight. In addition to previously mentioned test results, he considered a report dated September 28, 1989, from a Butte County Mental Health Services Neuropsychological Evaluation performed by Gerald Rowles, Ph.D., Staff Psychologist. Dr. Rowles performed the WAIS-R, utilizing seven subtests and obtained the following results:

Verbal IQ: 98                  Performance IQ: 85                  Full Scale IQ: 91

These scores were consistent with low average range of current intellectual functioning and the FSIQ "is consistent (identical) with scores on 2 previous (post-trauma) testings."

Dr. Luz offered the following:

**DIAGNOSTIC IMPRESSIONS  
DSM-III-R**

Axis I:                  310.10 Organic Personality Disorder  
Axis II:                  R/O (301.81) Narcissistic personality Disorder (Premorbid)  
Axis III:                  Closed Head Trauma (01-16-83)  
Axis IV:                  Code: 5 Serious, chronic organic factors  
Axis V:                  Current GAF: 41                  Best level this year: 50

58. Dr. Luz testified that “Organic Brain Syndrome” defined in the DSM-III would currently be termed “Mental Disorder Due to General Medical Condition.”

When asked if he agreed with Dr. Hayman’s diagnosis of mental retardation, Dr. Luz responded that “as a psychologist I would stay within the DSM.” He suggested that it was a “neurological condition that causes a situation similar to mental retardation.” Dr. Luz testified that he was not very familiar with the regional center requirements for eligibility or definitions of developmental disabilities.

When asked if “Psychotic Condition Due to General Medical Condition” would be appropriate, Dr. Luz testified, “I don’t know if it would be better accounted for by another mental disorder; I don’t know what that would be.”

59. The DSM-IV-TR sets forth the following:

Diagnostic Criteria for 293.xx Psychotic Disorder Due to . . .  
[Indicate the General Medical Condition]

- A. Prominent hallucinations or delusions.
- B. There is evidence from the history, physical examination, or the laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C. The disturbance is not better accounted for by any another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium.

*Code based on predominant symptom:*

**.81 With Delusions:** if delusions are the predominant symptom

**.82 With Hallucinations:** if hallucinations are the predominant symptom

### *Claimant’s Testimony*

60. Claimant testified that has been living at the Country Villa Merced for over four years and hates everything about it. He finds the group time “very elementary” and stated that the teachers are illegally licensed; he has investigated and almost the entire facility is illegal. He does not really have any friends but gets along well with everyone. He does not like personal communication; it makes him uncomfortable because he has been raped so many times.

He explained that in his previous placement, he did not take his medications and he had to find another place to live. He refused to take his medications because he didn't need them. His medications don't work and he is not really being given medicines but is being given poison to kill him. The doctor's are illegal and Pam Bright is a nurse that is playing the part of Dr. Soo Chun.

Claimant also testified that he is a neurologist and has discovered a cure for epilepsy that works. He believes that adding Phenobarbital before bed would totally stop seizures. He is also a general in the marines and has forty three zillion dollars at Bank of the West.

Claimant stated that he personally feels he does not need mental health services; it has "totally messed up" his life. He liked it when he was at Fred Finch. School was going well and he had a nice social life on Telegraph Avenue in Berkeley.

#### *Eligibility Based on Mental Retardation*

61. Claimant contends that the evidence shows that he has a "condition that is or is closely related to mental retardation, and that significantly limits his functioning in at least three major life areas.

62. Dr. Hayman diagnosed claimant in April, 2012, as having mild mental retardation and a mental disorder, not otherwise specified.

63. 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:

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

*General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence scales for children, 3<sup>rd</sup> Edition; Stanford-Binet, 4<sup>th</sup> Edition; Kaufman Assessment Battery for

Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement 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 Code based on the degree of severity reflecting level of intellectual impairment:

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

64. Claimant's general intellectual functioning, based on his IQ scores set forth above, did not meet the definition of significantly subaverage intellectual functioning under the DSM-IV-TR.

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

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

66. There was no evidence presented that claimant qualified for special education as a student with mental retardation. In May 1983, four months after the accident, the recommendation of the Butte County Special Services Department was that claimant "would probably benefit best from a structured setting which will assist him directly in his language

acquisition and academic disabilities. In the fall he will most likely be ready to participate in the regular program providing he has support from a Resource Specialist Program and Speech and Language Specialist.” Diane Golden, Language, Speech and Hearing Specialist recommended “placement in a classroom where emphasis would be on language retrieval and remediation.”

67. Academic testing performed five months post accident by Lee Funk, Butte County Schools, showed the following achievement grade scores determined by the Woodcock Johnson Psycho-educational Battery:

	<u>Grade Score</u>
Reading:	8.0
Math:	7.0
Written Language:	4.3
Knowledge Cluster (Science, Social Studies, Humanities)	6.3

acquire academic skills up to approximately the sixth-grade level

At that time, claimant had already acquired academic skills in excess of the maximum level expected for individuals with even mild mental retardation.

Claimant passed his high school math competency in the spring of 1983 and later received a high school diploma.

68. Dr. Wardinsky disagreed with Dr. Hayman’s diagnosis in several ways. He explained his confusion after reading Dr. Hayman’s report which he believed “describes a person with psychosis and then lands on mild mental retardation.” There was no consideration of IQ testing to demonstrate mild mental retardation, and mental retardation is not a condition closely related to mental retardation, it is mental retardation.

69. Dr. Root testified that, in her capacity as ACRC staff psychologist, she routinely performs assessments and reviews those performed by her colleagues, for the purpose of determining the existence of developmental disabilities. After reviewing claimant’s extensive records, her testimony was persuasive that there was no evidence to demonstrate that claimant was an individual with mental retardation prior to age eighteen.

70. It appears that Dr. Hayman, while having vast medical/psychiatric knowledge, was unfamiliar with the requirements specific to the Lanterman Act for consumers to qualify based on mental retardation. There was no evidence to support his finding of mild mental retardation or the “corrected” moderate mental retardation. And an individual with mental retardation would not have a “condition similar to mental retardation” making that finding inconsistent.

71. All testing of claimant’s intellectual abilities prior to age eighteen indicates that he was in the low average to average range of intelligence.

72. The evidence presented demonstrates that claimant is not eligible for ACRC services based upon a diagnosis of mental retardation.

*Eligibility Based on the “Fifth Category” (A Disabling Condition Found to be Closely Related to Mental Retardation or to Require Treatment Similar to Mental Retardation)*

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

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

74. Claimant’s general intellectual functioning is not significantly subaverage. All testing of claimant’s intellectual abilities prior to age eighteen indicates that he was in the low average to average range of intelligence. Thus, claimant does not have this “essential feature” of mental retardation.

75. Claimant contends that he is qualified to receive services under the fifth category because deficits in his adaptive functioning demonstrate that he either has a condition closely related to mental retardation, or that he requires treatment similar to that received by individuals with mental retardation.

76. Fifth category eligibility determinations typically begin with an initial consideration of whether claimant had global deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed. Claimant contends that “he requires substantial treatment, particularly in adaptive skills and supports, similar to those required for individuals with mental retardation.” Therefore, he is focusing on his significant limitations in adaptive functioning and need for treatment similar to that provided to individuals with mental retardation

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

independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Here, claimant believes he requires treatment similar to that required for individuals with mental retardation. He also believes that his condition is closely related to mental retardation.

*Fifth Category Eligibility-Condition Closely Related to Mental Retardation*

78. Claimant contends that he remains eligible for regional center services based upon his condition being closely related to mental retardation due to his impairments in adaptive functioning. The DSM-IV-TR explains that “adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.” Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and generic medical conditions that may coexist with Mental Retardation.

79. The DSM-IV-TR also explains that deficits in adaptive functioning can have a number of causes. The fact that claimant has significant deficits in adaptive functioning alone without significant impairment in general intellectual functioning prior to age eighteen is not sufficient to establish that he has a condition closely related to mental retardation. Claimant’s diagnoses over the years have included Post-Concussion Syndrome, Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, Psychotic Disorder NOS, Dependent Personality Disorder, Passive-Aggressive Personality Disorder and Narcissistic Personality Disorder. He has also been found to have delusions and psychotic behavior. Any of these conditions could cause his adaptive functioning difficulties.

80. Claimant’s witnesses testified that he has Frontal Lobe Syndrome. Dr. Wardinsky testified that Frontal Lobe Syndrome is not closely related to mental retardation. A syndrome is not a condition but a group of commonly co-occurring symptoms with a common etiology. Syndromes (i.e. Down Syndrome) present differently in different people. Individuals with Down syndrome, for example, would only be found eligible if they met one of the five eligible conditions.

81. Dr. Hayman testified that often this “syndrome goes unnoticed clinically” By contrast, mental retardation does not go unnoticed and the more severe the mental retardation, the more pronounced it is. While “psychological test results may be normal on one administration and not another” (with Frontal Lobe Syndrome), mental retardation can be measured on standardized tests of global intellectual functioning. Dr. Root explained that various factors may cause an individual with mental retardation to score lower than they are able but one would never achieve scores higher than what one is capable of achieving. Thus mental retardation does not appear and then disappear.

He also testified that other Frontal Lobe Syndrome presentations include suicidal ideation, increased sexual behaviors, and “confabulations” which can include grandiose,

fantastical or fantasy-like confabulations, disinhibition and aggression. There was no evidence that mental retardation causes these same behaviors.

82. Dr. Wardinsky testified that traumatic brain injuries can lead to mental retardation but that does not imply that a TBI is closely related to mental retardation. Psychological assessments consistently found claimant to be functioning in the low average to average range.

Records also clearly indicate claimant's behavior difficulties which began years prior to the accident. Adaptive functioning difficulties may result from behavior and/or personality disorders.

There was no convincing evidence that Frontal Lobe Syndrome or Psychotic Disorder Due to TBI are closely related to mental retardation.

83. ACRC does not dispute that claimant has significant deficits in adaptive functioning but asserts that such deficits may have a number of causes, as noted in the DSM-IV, which may occur in the absence of significant deficits in general cognitive ability. Claimant has been diagnosed with various mental health disorders and has a well established history of behavioral concerns. Dr. Root and Dr. Wardinsky opined that claimant's deficits in adaptive functioning are most likely caused by his mental health problems.

There is no evidence that deficits in claimant's adaptive functioning are related to any cognitive deficits. In this respect, it does not parallel traditional fifth category analysis that looks for subaverage intellectual functioning "accompanied by" significant limitations in adaptive functioning. Dr. Root's testimony is persuasive that if claimant's adaptive deficits derive from his mental health diagnoses, such is inconsistent with a finding that his condition is closely related to mental retardation. She opined that claimant's deficits in adaptive functioning are better addressed by continued medication and from the treatment perspective of one with mental health disorders.

84. Claimant's history is not consistent with a degree of global intellectual impairment and similar manifestations of cognitive and adaptive functioning deficits as those possessed by persons with mental retardation. Claimant's general level of cognitive functioning is within the average range. The fact that claimant has significant deficits in adaptive functioning alone, without global intellectual impairment prior to age eighteen, does not establish that he has a condition closely related to mental retardation.

*Fifth Category Eligibility-Condition Requiring Treatment Similar to that Required by Individuals with Mental Retardation*

85. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required by individuals with mental retardation. "Treatment" and "services" do not mean the same thing. They have separate meaning. Individuals without developmental

disabilities may benefit from many of the services and supports provided to regional center consumers. Section 4512, subdivision (b) defines “services and supports” as follows:

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

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

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

86. Fifth category eligibility must be based upon an individual requiring “treatment” similar to that required by individuals with mental retardation. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to mental retardation. One would not need to suffer from mental retardation, or any developmental disability, to benefit from the broad array of services and supports provided by ACRC to individuals with mental retardation. They could be helpful for individuals with other disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, in order to be found eligible.

87. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility both needing “many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training,

specialized teaching and skill development approaches, and supported employment services.” (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493. .) This broader characterization of “treatment” cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, vocational training, or money management, to qualify under the fifth category without more. For example, such services as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual’s condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearing, supra*, 89 Cal.App.4th 1119.) Furthermore the various additional factors required as designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id.* at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id.* at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Ca.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: “it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of ‘developmental disability’ so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services.” (*Id.* at p. 1129.)

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

88. Dr. Wardinsky testified that treatment for individuals with mental retardation or low global intellectual functioning involves simplification of content and form of information,

using more concrete terms and simpler vocabulary, breaking information down to small bits and using repetition to assist in learning. When FNRC first determined that claimant was eligible for regional center services, he was still in the hospital in the rehabilitation unit. The evidence showed that the type of treatment he required at that time was rehabilitation in the areas of speech, language and mobility. There was no indication that claimant would require treatment similar to that required by individuals with mental retardation. When claimant was originally diagnosed, he was still in rehabilitation. He was re-learning some former skills not attempting to learn new ones. There was no indication that he needed treatment similar to an individual with mental retardation.

89. Dr. Root explained that claimant was receiving therapy to assist in physical rehabilitation and regaining speech and language. He was re-learning some former skills due to his traumatic injury, not attempting to learn new ones. There was no evidence at that time that claimant needed treatment similar to that required by an individual with mental retardation in order to learn.

90. Drs. Wardinsky and Root also testified that at the time of the February 15, 1983, social assessment, even the medical professionals could not determine claimant's prognosis. He was beginning rehabilitation therapies for his serious injuries and it would have been impossible to know if claimant had a condition, which like mental retardation, is lifelong or would be substantially disabling. At that time, the focus was on claimant's emergent needs. Evidence shows that, in fact, claimant made a remarkable recovery in a lot of ways.

91. Dr. Root testified that the definition of developmental disability may be different in the Lanterman Act than in other contexts. Treatment in the Lanterman Act is condition-based, not needs based. Consideration is given to the method of delivery of the service; the way a service is applied. She used an example of financial planning or assistance with money management. How that assistance would be provided to a professional would be different than how it would be provided to a layperson. And the method would differ in content and delivery provided to an individual with mental retardation and an individual with average intelligence. "Individuals with mental retardation might need simpler vocabulary, the use of more concrete terms, and they may need to start with topics such spending money rather than beginning with explaining how to invest in the stock market. Individuals with mental retardation would typically need information presented in smaller chunks, and repeated frequently to assist them to learn. An individual with average intelligence could be addressed with more complex vocabulary and information would not need to be presented in small chunks or repeated." There is no evidence that claimant requires to be treated like an individual with mental retardation in order to learn. She opined that a similar treatment would be inappropriate for claimant's functioning level and that claimant's limiting conditions would be better served from a treatment perspective of one with mental health concerns.

The provision of any service or support to an individual with mental retardation would necessarily differ significantly in manner and delivery from that provided to an individual with average intelligence. In this respect, individuals with mental retardation would be "treated" differently and thus require different "treatment" than individuals with average intelligence.

92. There were no school records indicating that claimant required treatment similar to an individual with mental retardation.

93. Dr. Haapanen concluded that claimant requires a “structured living placement” that can “apply external limits of behavior which can be loosened as [claimant] can show awareness of and willingness to conform to the needs and values of others.” There was no evidence that this structure was required to address cognitive limitations but rather was to address claimant’s behavioral concerns. He also recommended out-of-home placement due to the “limitations of the parents’ ability to provide the extensive time and involvement required to promote changes in [claimant’s] thinking and behavior.” There was no evidence that the behaviors claimant was exhibiting were characteristic of individuals with mental retardation or that such individuals require this treatment to promote changes in their thinking and behavior.

He also recommended “extensive individual therapy, regardless of an out-of-home placement.” There was no indication that this individual therapy is a treatment required by individuals with mental retardation.

94. Dr. French suggested that claimant may benefit from treatment with lithium. He also recommended that claimant “be hospitalized for a period of time with the specific objective of pursuing pharmacologic means to control his impulsivity and advise him that his future is extremely limited and that he needs to find some appropriate outlet, which will not lead to further grief, for his feminine interest.” There was no evidence presented that lithium administration and/or hospitalization, to pursue pharmacologic means to control impulsivity, are treatments required by individuals with mental retardation.

95. Other recommendations included “social skills training” and use of “token economy or response-cost system.” There was no evidence that these behavioral strategies or treatments are required by individuals with mental retardation.

96. No persuasive evidence was presented to demonstrate that claimant required treatment similar to that required by individuals with mental retardation.

#### *Eligibility based on Epilepsy*

97. Claimant contends that he suffers from a seizure disorder and is “currently prescribed Dilantin and Topamax, both drugs that are intended to control seizures and that are frequently prescribed to persons having epilepsy.” He asserts that this “seizure disorder falls in the spectrum of epileptic disorders that, if uncontrolled, significantly limits his life activities of self-care, capacity for independent living, and economic self-sufficiency. This limitation arose before age eighteen as claimant self reports having seizures before age five and after his accident.

Claimant concludes that he is eligible for regional center services because ‘he has a seizure disorder that is either epilepsy, and the term has just not been used in his diagnosis, or

his condition is equivalent to epilepsy as he takes medication on a daily basis to control it, and he would therefore qualify as developmentally disabled.”

98. Dr Root and Dr. Wardinsky testified that they found no evidence of seizures prior to age eighteen and concluded that claimant could not be found eligible for regional center services based upon epilepsy

99. Dr. Hayman testified that no adequate assessment was done so he’s “not sure, can’t tell.”

100. The evidence was conflicting but did not demonstrate that claimant was not diagnosed with epilepsy that was substantially disabling prior to age eighteen.

### *Comprehensive Reassessment*

101. Claimant contends that ACRC did not conduct the “comprehensive reassessment” required pursuant to section 4643.5, subdivision (b), prior to concluding that the original determination that claimant had a developmental disability was clearly erroneous. He alleged that “no reassessment was performed at all. Alta California did not have a physician examine [claimant]; there was no medical doctor involved in the decision in any meaningful way. Alta California relied on incomplete medical records, and it did not order diagnostic tests.” “Alta California failed to perform any sort of current testing, clinical exams, or psychological evaluations on [claimant] to see if he had and continued to exhibit a developmental disability.”

102. Specifically, claimant argued that ACRC had failed to order an MRI for claimant after it was recommended by Dr. Hayman and requested by claimant’s conservator. ACRC denied the request after determining that it would not be meaningful.

103. ACRC argued convincingly that no new psychological or medical evaluations or exams were needed to perform a comprehensive reevaluation. It was clear that an extensive record review was conducted which provided sufficient information regarding claimant’s abilities and functioning. There was no evidence that additional testing or examination of this forty-four year old man would provide any meaningful information about his intellectual and adaptive functioning, or existing condition, prior to age eighteen.

## 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.

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

2. Once a consumer has been found eligible for regional center services, the Lanterman Act requires that any reassessment of eligibility be “comprehensive.” Eligibility cannot be revoked unless the “comprehensive reassessment” causes the regional center to conclude that the original determination was “clearly erroneous.” (Welf. & Inst. Code, § 4643.5, subd. (b)).

The Act does not provide a definition of comprehensive though the intent appears to require it to be inclusive of all information necessary to make an accurate determination. Section 4643, subdivision (b) offers some guidance by setting forth items that may be considered for an original determination of eligibility as follows:

4643 (b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluation and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological test, diagnostic test performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from other sources.

3. An original determination may be found to be clearly erroneous because the individual did not have one of the qualifying conditions set forth in section 4512; that is he does not have mental retardation, cerebral palsy, epilepsy, and autism, or a disabling condition found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation [“fifth category”].

An original determination may also be found to be clearly erroneous when an individual does have one of the qualifying conditions but the condition did not constitute a substantial disability for the individual. If reassessment concerns substantial disability, section 4512, subdivision (l) requires:

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

California Code of Regulations, Title 17, Section 54001(b) specifies:

The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist

In this matter, ACRC did not base its reassessment on a determination that claimant's disability does not constitute a substantial disability for him. Instead, reassessment was based on the conclusion that claimant did not have a qualifying condition pursuant to section 4512. Having determined that claimant did not have one of the qualifying conditions, the team could not, and was not required to, assess whether he was substantially disabled by one of those conditions.

4. ACRC established that a comprehensive reassessment was performed. There was no evidence provided to show lack of consideration of any relevant information establishing claimant's original eligibility prior to age eighteen. Current testing, clinical exams, or psychological evaluations of a now forty-four year old man would not be conclusive of his qualification for services at or prior to age eighteen.

Claimant's argument that the reassessment was flawed because no medical doctor appears to have participated is without merit. The reassessment was comprehensive in scope of information reviewed and individuals who participated in the review and determination of ineligibility.

5. FNRC Program Coordinator Nancy Cornell's Core Staff Conference Report dated March 8, 1983 found claimant eligible for regional center services after a "screening" which concluded that claimant had a diagnosis of "Associated Neurological Handicap due to trauma or physical agent" with a substantial handicap that is likely to continue indefinitely. There was no evidence that claimant was assessed prior to this determination

By the time of the March 21, 1983, Core Staff Conference report thirteen days later, three of the "substantial handicaps that are likely to continue indefinitely," were no longer substantial or likely to continue indefinitely. There was no evidence of input from a physician which seems critical considering claimant was still in the hospital rehabilitating from his injuries. Nor was there evidence of input from a psychologist which would have been required to assess claimant's level of intellectual functioning, especially if "fifth category" eligibility was being considered.



## 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).)**