

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of the Fair Hearing Request of:

Michael M.,

Claimant,

and

North Los Angeles County Regional Center,

Service Agency.

OAH No. 2013070598

**DECISION**

This matter was heard by Kara K. Hatfield, Administrative Law Judge, Office of Administrative Hearings, State of California, on October 14, 2013, in Van Nuys, California. The North Los Angeles County Regional Center (Service Agency) was represented by Stella Dorian, Contract Officer. Claimant Michael M.<sup>1</sup> represented himself.

Evidence was received by documents and testimony. The record was closed and the matter was submitted for decision on October 14, 2013.

**ISSUE**

Is Claimant eligible to receive services from the Service Agency?

**EVIDENCE RELIED UPON**

*Documents:* Service Agency's Exhibits 2-18; Claimant's Exhibits A-B

*Testimony:* Sandi Fischer, Ph.D.; Michael M.

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<sup>1</sup> Initials and family ties are used to protect the privacy of claimant and his family.

## FACTUAL FINDINGS

1. Claimant was born in 1954, and is currently 59 years old.
2. Claimant has applied to receive services from the Service Agency under the Lanterman Developmental Disabilities Services Act (Lanterman Act). In a letter and Notice of Proposed Action dated July 5, 2013, the Service Agency denied eligibility, asserting that Claimant did not have a condition that made him eligible for services. Claimant submitted a request for fair hearing dated July 6, 2013, and this hearing ensued.
3. Claimant requests services from the Service Agency but does not identify any specific category of eligibility for services, and affirmatively denies meeting one category of eligibility: mental retardation. For the reasons set forth below, Claimant's appeal is denied.
4. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a generally-accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. Since 1917, the predecessor of the American Psychiatric Association has developed and published standards for and nomenclature of mental disorders. The American Psychiatric Association Committee on Nomenclature and Statistics developed and published the first edition of Diagnostic and Statistical Manual: Mental Disorders (DSM-I) in 1952. Subsequent editions were the DSM-II, DSM-III (1980), DSM-III-R (1987), DSM-IV (1994), and DSM-IV-TR (2000).<sup>2</sup> The most recent edition is the DSM-5, published in May 2013.
5. Between the time of Claimant's most recent evaluation and the date of the hearing in this matter, DSM-IV-TR was succeeded by DSM-5. DSM-5 no longer recognized a specific diagnosis of autistic disorder. Instead, it established a diagnosis of autism spectrum disorder which encompassed disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder. (DSM-5, p. 53.) All of Claimant's evaluations were performed before DSM-5 was released, and they referred to the diagnostic criteria set forth in DSM-IV-TR. However, the diagnostic criteria for Autism Spectrum Disorder in DSM-5 differ to a certain degree from those of Autistic Disorder in DSM-IV-TR. Therefore, the data contained in the evaluations, and Claimant's condition, were addressed at the hearing using both the criteria in DSM-IV-TR and those in DSM-5. This Decision will do the same.

6. Similarly, between the time of Claimant's most recent evaluation and

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<sup>2</sup> <http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual>. The Administrative Law Judge takes official notice of the history and contents of the DSM-IV and its successor DSM-5 as highly respected and generally accepted tools for diagnosing mental and developmental disorders.

the date of the hearing in this matter, DSM-IV-TR was succeeded by DSM-5, which no longer recognizes a specific diagnosis of mental retardation. Instead, it established a diagnosis of intellectual disability. (DSM-5, p. 33.) All of Claimant's evaluations were performed before DSM-5 was released, and they referred to the diagnostic criteria set forth in DSM-IV-TR. However, the diagnostic criteria for intellectual disability in DSM-5 differ to a certain degree from those of mental retardation in DSM-IV-TR. Therefore, the data contained in the evaluations, and Claimant's condition, were addressed at the hearing using both the criteria in DSM-IV-TR and those in DSM-5. This Decision will do the same. Those criteria are set forth below.

*Definition of Autistic Disorder/Autism Spectrum Disorder*

7. Under DSM-IV-TR, the diagnostic criteria for autistic disorder were:
  - A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):
    - (1) qualitative impairment in social interaction, as manifested by at least two of the following:
      - (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
      - (b) failure to develop peer relationships appropriate to developmental level
      - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
      - (d) lack of social or emotional reciprocity
    - (2) qualitative impairments in communication as manifested by at least one of the following:
      - (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)
      - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
      - (c) stereotyped and repetitive use of language or idiosyncratic language
      - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
    - (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
- (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- (d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

(DSM-IV-TR, p. 75.)

8. The DSM-5 lists criteria which must be met to provide a specific diagnosis of Autism Spectrum Disorder, as follows:

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):
  - 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
  - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
  - 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

*Specify current severity:*

**Severity is based on social communication impairments and restricted repetitive patterns of behavior . . . .** [Italics and bolding in original.]

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
  3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
  4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

*Specify current severity:*

**Severity is based on social communication impairments and restricted, repetitive patterns of behavior . . . .** [Italics and bolding in original.]

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

**Note:** Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder. [Bolding in original.]

(DSM-5, pp. 50-51.)

*Definition of Mental Retardation/Intellectual Disability*

9. The DSM-IV-TR described Mental Retardation as follows:

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

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a

measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR, pp. 41-42.)

10. Regarding Mild Mental Retardation (IQ level of 50-55 to approximately 70), the DSM-IV-TR stated:

[Persons with Mild Mental Retardation] typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. By their adult years, they usually achieve social and vocational skills adequate

for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

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

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

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

*(Id. at p. 48.)*

12. In the DSM-5,

[T]he diagnosis of intellectual disability (intellectual developmental disorder) is revised from the DSM-IV diagnosis of mental retardation. The significant changes address what the disorder is called, its impact on a person's functioning, and criteria improvements to encourage more comprehensive patient assessment.

...

Intellectual disability (intellectual developmental disorder) as a DSM-5 diagnostic term replaces "mental retardation" used in previous editions of the manuals. In addition, the parenthetical name "(intellectual developmental disorder)" is included in the text to reflect deficits in cognitive capacity beginning in the developmental period. Together, these revisions bring DSM into alignment with terminology used by the World Health Organization's International Classification of Diseases, other professional disciplines and organizations, such as the American

Association on Intellectual and Developmental Disabilities, and the U.S. Department of Education.

(DSM-5 Intellectual Disability Fact Sheet, p. 1.<sup>3</sup>)

13. The DSM-5 lists criteria which must be met to provide a specific diagnosis of Intellectual Disability, as follows:

Intellectual disability (intellectual development disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience, and practical understanding confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, and across multiple environments, such as home, school, work, and recreation.
- C. Onset of intellectual and adaptive deficits during the developmental period.

**Note:** The diagnostic term Intellectual Disability is the equivalent term for the ICD-11 diagnosis of Intellectual Developmental Disorders. Although the term Intellectual Disability is used throughout this manual, both terms are used in the title to clarify relationships with other classification systems. Moreover, a federal statute in the United States (Public Law 111-256, Rosa's law) replaces the term mental retardation with intellectual disability, and research journals use the term Intellectual Disability. Thus, Intellectual Disability is the term in common use by medical, educational, and other professions,

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<http://www.dsm5.org/Documents/Intellectual%20Disability%20Fact%20Sheet.pdf>

and by the lay public and advocacy groups. [Bolding in original.]

*Specify current severity (see Table 1):*

**317 (F70) Mild**

**318.0 (F71) Moderate**

**318.1 (F72) Severe**

**318.2 (F73) Profound** [bolding in original]

(DSM-5, p. 33.)

14. The DSM-5 explains that “[t]he various levels of severity are defined on the basis of adaptive functioning, and not on IQ scores, because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.” (*Id.*)

15. With respect to Criterion A,

Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65-75 ( $70 \pm 5$ ). Clinical training and judgment are required to interpret test results and assess intellectual performance.

...

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situation and mastery of practical skills. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding and other areas of adaptive functioning that the person’s actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

(*Id.* at p. 37.)

*“Fifth Category” Eligibility Guidelines*

16. Welfare and Institutions Code section 4512, subdivision (a) defines eligibility for regional center services as including developmental disabilities that are

“found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation . . . .” Eligibility on this basis is referred to as the “fifth category.” In 2002, the Association of Regional Centers promulgated “Guidelines for Determining ‘5th Category’ Eligibility for the California Regional Centers” (Guidelines). [SA Ex. 17, pp. 1-5] The Guidelines dictate that for an individual’s condition to be considered “closely related to mental retardation,” the individual’s general IQ score should fall within the low borderline range of intelligence, i.e. ranging from 70-74, and that the higher the score above 70, the less similar to mentally retarded a person should be considered. [*Id.* at p. 2.] According to the Guidelines, the higher an individual’s IQ score rises above 70, the more increasingly essential it is to demonstrate substantial adaptive deficits, and that these deficits are “clearly related to cognitive limitations.” [*Ibid.*] The Guidelines also dictate that, where an individual has an IQ score in the low borderline range of IQ 70-74, but with discrepant subtest scores such that any subtest score exceeds 85, “the more difficult [it is] to describe the individual’s general intellectual functioning as being similar to that of a person with mental retardation. [*Ibid.*] In some cases, these individuals may be considered to function more like persons with learning disabilities than persons with mental retardation.” [*Ibid.*]

17. With respect to eligibility under the alternate language in the fifth category, as an individual who “requires treatment similar to that required for individuals with mental retardation,” the Guidelines state that the eligibility team should consider the nature of the training and intervention required for an individual who does have global cognitive deficits, for example, in pertinent part, that “individuals who require long term training with steps broken down into small, discrete units taught through repetition may be eligible.” [*Id.* at p. 3.]

*1959-1962 Los Angeles Unified School District Records*

18. Contained within Claimant’s school records from the Culver City Unified School District (CCUSD) are a few records from the Los Angeles Unified School District (LAUSD), where claimant attended school from 1959-1962. On May 5, 1961, when Claimant was seven years and one month old, he was administered the Stanford-Binet test and was reported to have an IQ of 59. The “Individual Test Record” has the handwritten notation, “Mentally defective. Place in Specia[1] Training.”[SA Ex. 4, p. 54-55; 52] In June 1961, he was retained. [SA Ex. 4, p. 52-53] Claimant’s Cumulative Record for Elementary School Pupil – Los Angeles City Schools contains the following handwritten dates and entries from his teachers in the category of “Summary and observations of child: Emotional growth and control, social adjustment, work habits, special abilities, interests, etc.”:

6-19-59: Is frail, poorly coordinated, and seemingly very immature – all efforts seem very ineffective

1-61: Does not respond – very slow in all activities – Retained

6-61: Very slow. Poor social adjustment. Retained

1-62: Short span of concentration

6-62: Poor coordination. Fearful of new situations. Not responsive. Requires teacher's supervision.

*1962-1973 Culver City Unified School District Records*

19. Claimant enrolled with the CCUSD for the 1962-1963 school year when he was eight and one half years old. He was placed in the first grade. After the first semester, the school debated whether to place him in special training, as recommended by LAUSD and ultimately decided that despite Claimant's advanced age and "low index" 19 months earlier, he would not be reassigned to special training. Claimant's first grade teacher recommended against reassigning Claimant because Claimant was "reading with the better reading group in the class," was "very attentive in school and reflect[ed] a sincere desire to learn," "gave every indication of enjoying school," "reflect[ed] joy when he me[t] with success," "appear[ed] to be very happy in classroom," "laugh[ed] frequently," and was liked by the children. [SA Ex. 4, p. 48]

20. Claimant was administered the Stanford-Binet intelligence test on December 15, 1963 (during second grade) and he "scored 70." [SA Ex. 4, p. 40]

21. Claimant was administered the Wechsler Intelligence Scale for Children (WISC) in January 1964 (during second grade) and his Verbal Scale score was 67, his Performance Scale score was 99 and his Full Scale score was 80. [SA Ex. 4, p. 40]

22. When Claimant was in fourth grade, in December 1965, the WISC was administered and sub-test scaled scores were reported. Overall, Claimant's Verbal IQ was 76, Performance IQ was 89 and Full Scale IQ was 80. The administering psychologist noted

Perceptual-motor retardation or impairment. Visual problem. Poor gross and fine coordination. Evidence of growth in verbal abilities; excellent word attack. Inability to comprehend number concepts and abstractions. Poor judgment in social situations. See attached report. [SA Ex. 4, p. 30]

According to the psychologist's typewritten report, when comparing Claimant's standardized IQ test scores from 1961, 1963, 1964 and 1965, "There is evidence of gradual development and growth in intellectual capacity, particularly in verbal areas." [SA Ex. 4, p. 40]

23. After starting in CCUSD in 1962, Claimant progressed to the second grade for the 1963-1964 school year, then to the third grade in 1964-1965, and the

fourth grade in 1965-1966. [SA Ex. 4, pp. 60 and 62, 59 and 61] When Claimant was assessed in December 1965, a grade adjustment was considered due to Claimant's age relative to other students in the fourth grade. Due to Claimant's "good adjustment to his class and the warm relationship with his present teacher," the school decided to "[r]e-evaluate for September placement; meanwhile maintaining place on EH [Educationally Handicapped] waiting list for possible inclusion in the EH program." [SA Ex. 4, pp. 40-41]

24. Claimant advanced to the fifth grade in the fall of 1966, when he was 12 and one half years old. To evaluate him for "Grade placement for February, 1967," he was administered the Stanford-Binet on December 8, 1966 and his reported IQ score was 72. [SA Ex. 4, p. 27] Psychologist Clarice Bennett made these typewritten notes as "Psychologist's observations/findings":

Results of 5 individual ability tests indicate that functioning in performance area falls in average range, but functioning in verbal area is in borderline range. However, classroom achievement as well as performance on achievement tests is not consistent with measured verbal ability and these results would indicate that verbal ability is actually higher. Because of the difficulty in establishing an expectancy, a professional estimate of ability in the low average range . . . is presented. [SA Ex. 4, p. 6]

25. On January 18, 1967, a CCUSD "Special Education Placement Recommendation," signed by the Assistant Superintendent – Educational Services, the Director of Pupil Personnel, the Principal, Claimant's "Teacher or Counselor," the School Physician or Nurse, the School Psychologist and two teachers of the EH Class, recommended

1. Ineligible for EMR [educable mentally retarded] placement.
2. Refer to EH Admission and Discharge Committee.
3. Social adjustment to 6th grade, effective 1-31-67.
4. Placement in 6th grade class taught by a man teacher.
5. Continued enrollment at Culver School for remainder of 1966-1967. [SA Ex. 4, p. 47]

On January 31, 1967, Claimant was "adjusted to 6th grade because of age." [SA Ex. 4, p. 4, 14, 58]

26. On June 9, 1969, when Claimant was at the end of eighth grade at age 15 years and three months, he again took the WISC<sup>4</sup> and his scores were reported as Verbal IQ of 79, Performance IQ of 93 and Full Scale IQ of 84. [SA Ex. 4, p. 27] Psychologist N.L. Shuman noted:

A language or educational defect is suggested by the 14 point difference between verbal and performance scales. Areas of strength are in alertness to environment and in ability to cope with the environment. Weakness is notable in practical judgment and in social adaptation. . . . Excessive concern about things in the environment may be a prime cause of Mike's academic difficulties. Guidance clinic should be recommended to combat anxiety. [SA Ex. 4, p. 28]

27. The CCUSD records contain documents from the Kennedy Child Study Center, requesting information from Claimant's teacher in October 1969. Claimant's ninth grade teacher, Mr. P. Longenbaugh, completed the 22 question "Behavior Rating Scale for Children" on November 21, 1969, when Claimant was 15 years and 8 months old. [SA Ex. 4, pp. 31, 33-35]

28. During Claimant's ninth, tenth, and twelfth grade years, he took several standardized achievement tests. The test administered in October 1972 during twelfth grade (when Claimant was 19 and one half years old) indicated a Verbal IQ of 89. [SA Ex. 4, pp. 8, 11, 13]

29. Claimant graduated from Culver City High School with a Diploma in June 1973. His cumulative GPA was 1.214 and ranked 511th out of 522 graduates. [SA Ex. 4, pp. 17, 18, 71] Claimant's "Summary – High School Record," prepared by counselor Patricia Logsdon, noted, "In counseling at Kennedy Center during all the time he was enrolled with us. Mr. McCully (counselor) feels it is miraculous that he made it through school." [SA Ex. 4, p. 18]

*1994 Psychological Evaluation for Westside Regional Center*

30. In September 1994, Claimant was 40 years old and applied for services through the Westside Regional Center. He was referred to Lawrence Hermann, Ph.D., a licensed psychologist, for "assessment of intellectual, social and emotional functioning . . . to help determine eligibility for Regional Center services and to assist in program planning." [SA Ex. 5, p. 1]

31. Dr. Hermann interviewed Claimant and described him as having  
no physical stigmata of mental retardation. His affect is rather odd; he seems overly friendly on first meeting and his

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<sup>4</sup> Another document, a CCUSD "Special Services Record," indicates the test was the Weschler Adult Intelligence Scale (WAIS) (with WISC being typed over with Xs). [SA Ex. 4, p. 21]

conversation is a bit tangential with constant references to his religion, but he does not present as retarded. He was fully cooperative during the evaluation and obviously attempted the tasks to the best of his ability. [SA ex. 5, p. 2]

32. Dr. Hermann administered the following standardized tests: Wechsler Adult Intelligence Scale - Revised (WAIS-R); Peabody Picture Vocabulary Test (PPVT-A); and Vineland Social Maturity Scale. He also administered other standardized tests: Wide Range Achievement Test (WRAT-3); Bender Gestalt Test; and Draw-A-Person Test (DAP). Claimant's score on the WAIS-R "was in the average cognitive range. This appears to be a good estimate of his global functioning; almost all of his major subtest scores fell within this range although his social skills seem more borderline." [SA Ex. 5, pp. 1, 3] Claimant's score on the Vineland Social Maturity Scale "matches that of an average eighteen year old. He has all of the skills necessary for basic self care plus demonstrated ability to function independently." [SA ex. 5, p. 4]

33. Dr. Hermann's summary and recommendations described Claimant as "functioning near the middle of the average cognitive range, with some deficits in arithmetic ability. [¶] [Claimant] does not appear to be eligible for Regional Center services on the basis of mental retardation or autism nor does his functioning seem similar to either category." [SA Ex. 5, p. 4]

34. In October 1994, the Westside Regional Center determined that Claimant was not eligible to receive the services of the Regional Center. [SA Ex. 6, pp. 1-2]

*2004 Psychological Evaluation for Westside Regional Center*

35. In November 2004, Claimant was 50 years old and again applied for services through the Westside Regional Center. He was referred to Lisa M. Doi, Ph.D., a licensed psychologist, "to determine his current levels of cognitive and adaptive functioning and for purposes of diagnostic clarification." Claimant was specifically assessed for autism. Dr. Doi interviewed Claimant and noted that

Throughout the session, no oddities of speech or repetitive motor mannerisms were noted. [Claimant] was cooperate [sic] and compliant. He demonstrated a strong desire to communicate and talked at length but generally only briefly addressing the question but added a considerable amount of extraneous information. He was noted to exhibit good effort on all tasks presented. [SA Ex. 7, p. 3]

36. Dr. Doi interviewed Claimant's father by telephone "to obtain information regarding developmental history." He reported that Claimant had been a "sensitive boy who wanted to make friends." He reported "that his son did not exhibit

any preoccupations, obsessions, oddities of speech, self-injurious behaviors or repetitive motor mannerisms.” [SA Ex. 7, p. 6]

37. Dr. Doi administered Module 4 of the Autism Diagnostic Observation Schedule (ADOS) to assess Claimant “for possible symptoms in the Autistic spectrum.” Dr. Doi’s Psychological Evaluation report states, “An examination of his behaviors and responses indicated scores below the Autism spectrum cutoff range in the areas of communication and reciprocal social interaction. His scores would not suggest a diagnosis in the Autistic spectrum.” [SA Ex. 7, p. 10]

38. In Summary and Conclusions, Dr. Doi stated,

Regarding possible symptoms in the Autistic spectrum, specifically in consideration of a diagnosis of Asperger’s disorder, it should be noted that the information provided by his father would not suggest symptoms of a pervasive developmental disorder. In addition, an examination of school records do [sic] not indicate the existence of preoccupations, nonfunctional routines or rituals, stereotyped behaviors or a persistent preoccupation with parts of objects. Finally, administration of the ADOS did not indicate the presence of symptoms of a pervasive developmental disorder. [SA Ex. 7, p. 7]

39. On January 6, 2005, the Westside Regional Center determined that Claimant was not eligible to receive the services of the Regional Center. [SA Ex. 8, p. 1]

*2005 Initial Assessment by Didi Hirsch Community Mental Health Center, Los Angeles County Department of Mental Health*

40. In February 2005, Claimant went to the Didi Hirsch Community Mental Health Center (Didi Hirsch), and Devon Kaist, M.A. (psych intern) completed a Crisis/Adult Initial Assessment form. Claimant reported a history of Asperger’s Disorder and the listed Admission Diagnosis included, among others, Asperger’s Disorder. [SA Ex. 18, p. 4] However, when Claimant’s case was presented to Guchy Elnekave, M.D., Asperger’s was not listed among the several diagnoses made by Dr. Elnekave. [SA Ex. 18, p. 6]

41. Claimant introduced into evidence a letter dated October 2, 2013, from the Didi Hirsch Administrative Coordinator, Adult Division, stating that Claimant had been seen at the Culver City office for mental health services from February 15, 2005, through November 29, 2006, on an outpatient basis and that his diagnoses were “Asperger’s Disorder, A Type Pervasive Dev, full; Psychotic Disorder NOS.” [Claimant’s Ex. A] Compared to data related in the psychological evaluation after comprehensive assessment by Dr. Doi, and considering that Asperger’s was noted as a possibility on intake at Didi Hirsch by a psychiatric intern, but not diagnosed by Dr.

Elnekave, the letter summarizing Claimant's diagnoses at Didi Hirsch is not persuasive evidence that he had Asperger's.

*2013 Evaluation by North Los Angeles County Regional Center*

42. In June 2013, Claimant was 59 years old and applied for services through the North Los Angeles County Regional Center (NLACRC). Sandi Fischer, Ph.D., a licensed psychologist on staff at NLACRC, reviewed Claimant's CCUSD records and the psychological evaluations conducted by Dr. Hermann in 1994 and Dr. Doi in 2004. Based upon these records, Dr. Fischer concluded that additional testing for Autism or mental retardation was "not necessary as available records include testing." [SA Ex. 9, p. 1-2] Dr. Fischer's Consumer I.D. Note dated June 26, 2013, concludes that "Claimant is clearly not mentally retarded and he is not similar to a person who is mentally retarded." After a meeting of the Service Agency's Multidisciplinary Eligibility Staffing Team, Claimant was informed in July 2013 that he is not eligible to receive the services of the Regional Center.

43. Dr. Fischer persuasively explained at hearing that Claimant does not have Autistic Disorder/Autism Spectrum Disorder, Mental Retardation/Intellectual Disability or a condition similar to mental retardation. With respect to mental retardation, of primary importance were the Claimant's WISC Full Scale IQ scores reported in 1964, 1965 and 1969, which were in the low average range. The increase in Claimant's Full Scale IQ scores over time was inconsistent with a person with mental retardation, whose IQ scores would not be expected to improve as greatly as Claimant's did over time. Also of importance were Claimant's scores on the various sub-tests, and his scores in the categories requiring abstract reasoning, which were in the average and above average ranges. With respect to Autistic Disorder/Autism Spectrum Disorder, of primary importance to Dr. Fischer's opinion was the fact that although certain remarks in Claimant's school records describe some behaviors that are characteristic of children with autism, there are many notations and remarks that indicate behaviors that would not at all be characteristic of autism, and the presence of which rules out a diagnosis of Autistic Disorder/Autism Spectrum Disorder during the developmental period (prior to age 18). For example, Claimant was noted to have a warm relationship with his teacher, would do anything for acceptance, was imaginative, accepted blame and apologized readily, and was conforming and obedient.

*Service Agency's Determination*

44. Service Agency's Eligibility Committee, consisting of a staff medical doctor, staff psychologist and staff intake specialist, found that Claimant did not have a developmental disability as defined by law and therefore was not eligible for services. Claimant was notified in July 2013.

### *Claimant's Testimony at Hearing*

45. Claimant testified credibly but tangentially at hearing. He did not offer any evidence that he meets any of the eligibility criteria for services from the Service Agency. He made no allegations and offered no evidence that he has epilepsy or cerebral palsy. The only evidence Claimant offered that he has any condition related to Autistic Disorder/Autism Spectrum Disorder was a letter from Didi Hirsch Mental Health Services stating that when he received mental health services in 2005 and 2006, he had a diagnosis of "Asperger's Disorder, A Type Pervasive Dev, full." [Claimant's Ex. A] However, that diagnosis is contradicted by a complete assessment for any disorders on the Autism spectrum performed by Dr. Doi in 2004, the diagnosis contained in Claimant's record from Didi Hirsch after an interview by Dr. Elnekave in 2005, and school records descriptions of Claimant's behaviors and functioning between the ages of 6 and 18.

46. Claimant attempted to discount Dr. Doi's assessment by stating that the information obtained from Claimant's father about his behaviors as a child was unreliable because Claimant's father didn't know him well because after his parents were divorced in June 1959, his mother had custody of him and he only saw his father by court-ordered visitation. Claimant also attempted to refute Dr. Doi's and Dr. Fischer's conclusions that he did not have any condition on the Autism spectrum by asserting that he in fact does have repetitive behaviors, obsessions, premonitions, and post-traumatic stress syndrome (due to an apartment fire where he lived two years ago).

47. Claimant specifically and repeatedly denied being mentally retarded. The only specific evidence Claimant offered relating to his functional abilities was a letter from Maureen Cyr, MSW, Psychiatric Social Worker at the Edmund D. Edelman Westside Mental Health Center dated November 10, 1999; that letter does not support any determination that Claimant has mental retardation or has a condition similar to mental retardation. The letter characterizes Claimant's functioning as more than adequate. Not only does Claimant care for himself, he also cares for and manages the affairs of his younger, developmentally disabled brother:

For the past nine years since their mother . . . died, [Claimant] has been managing [his and his brother's] money and allotting weekly amounts to his brother, while overseeing the payment of their rent, utilities, and food expenses. They have lived in the same house for many years and it appears that they are managing the financial aspects of their lives reasonably well . . . . [Claimant's Ex. B]

In conflict with the letter Claimant introduced into evidence, Claimant testified that he has "issues," like money management, and others. He stated there are some things he can do for himself, and others he can't, such as drive and therefore he uses the bus. He offered no other specifics. When asked why he can't do the things he can't do, he stated it is because his parents didn't give him proper training and left him home

alone a lot. He does not attribute his inability to do certain things to any cognitive or functional limitations of the type that would make him eligible for services from the Service Agency.

48. During hearing, Claimant was repeatedly invited to share information that would support his claim of eligibility, and he repeatedly failed to offer anything. Claimant stated that he doesn't know why he would be eligible for services from the Service Agency, but that he asked for help because he is "stuck" and needs help for him and his brother since his mother died 21 years ago. Claimant testified that in addition to the assessments conducted when he was a child in school, by Dr. Hermann in 1994 and Dr. Doi in 2004, he was assessed at Saint Ann's in 1994 and at Edelman in 1995. However, Claimant did not introduce any records of these assessments.

### LEGAL CONCLUSIONS

1. Claimant has not established that he suffers from a developmental disability entitling him to Service Agency's services.
2. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq.)
3. An administrative "fair hearing" to determine the rights and obligations of the parties is available under the Lanterman Act. (Welf. & Inst. Code, §§ 4700-4716.) Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700-4716, and Cal. Code Regs., tit. 17, §§ 50900-50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met his burden of proof in this case.
4. The Lanterman Act is a comprehensive statutory scheme to provide "[a]n array of services and supports . . . which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community." (Welf. & Inst. Code, § 4501.) The services and supports should "enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age." (*Id.*)
5. In enacting the Lanterman Act, the Legislature codified the state's responsibility to provide for the needs of developmentally disabled individuals and recognized that services and supports should be established to meet the needs and choices of each person with developmental disabilities. A regional center is required

to provide services and supports for eligible consumers in accordance with the Lanterman Act. (Welf. & Inst. Code, § 4500 et seq.)

6. To be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512, subdivision (a), defines “developmental disability” as:

a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . [T]his term shall include mental retardation, cerebral palsy, epilepsy and autism. 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, but shall not include other handicapping conditions that are solely physical in nature.

7. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a “substantial disability.” Pursuant to Welfare and Institutions Code section 4512, subdivision (1):

“Substantial disability” means the existence of significant functional limitations 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.

8. California Code of Regulations, title 17, section 54001 states, in pertinent part:

(a) “Substantial disability” means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as

determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

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

9. In addition to proving a “substantial disability,” a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism<sup>5</sup> and cerebral palsy. The fifth and last category of eligibility is listed as “disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512, subd. (a).)

10. The Legislature did not define the fifth category, requiring only that the qualifying condition be “closely related” (Welf. & Inst. Code, § 4512, subd. (a).) or “similar” (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or that it “require treatment similar to that required for mentally retarded individuals.” (Welf. & Inst. Code, § 4512, subd. (a).) In a recent case, the appellate court decided eligibility in the fifth category may be based on the established need for treatment similar to that provided for individuals with mental retardation, notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462, 1490, 1492-1493.) 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. (*Ibid.*)

11. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of “developmental disability” (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric

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<sup>5</sup> The plain language of the Lanterman Act's eligibility categories includes “autism,” but it does not include the other PDD diagnoses in the DSM-IV-TR (Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD-NOS). The Lanterman Act has not been revised since the publication of the DSM-5 to reflect the current terminology of Autism Spectrum Disorder, and Intellectual Disability (in place of Mental Retardation).

disorders or solely learning disabilities. Therefore, impaired intellectual or social functioning which originated as a result of a psychiatric disorder, if it was the individual's sole disorder, would not be considered a developmental disability. Nor would an individual be considered developmentally disabled whose only condition was a learning disability. A learning disability is "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." (Cal. Code Regs, tit.17, § 54000.)

12. The term "cognitive" is defined as "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience." (Cal. Code Regs, tit.17, § 54002.)

### *Analysis*

13. Claimant has not established that he suffers from a developmental disability entitling him to Service Agency's services. Claimant made no direct assertions of a particular basis of eligibility and offered no credible evidence that he, before the age of 18 years, had mental retardation, cerebral palsy, epilepsy, 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. The records from the relevant developmental period (prior to age 18) demonstrate that although Claimant was suspected of having mental retardation when he was in kindergarten, all three WISC IQ test results obtained after Claimant was in first grade indicate an IQ in the low average range, as demonstrated by Full Scale IQ scores of 80, 80, and 84, which does not qualify as mental retardation. The DSM-5 explanation of Intellectual Disability maintains the DSM-IV-TR's description of the level of intellectual functioning typically meeting the definition of mental retardation as Full Scale IQ scores below 70.

14. The evidence does not support any finding that despite Claimant's IQ not meeting the definition of mental retardation/intellectual disability, Claimant's adaptive functioning is so poor that it compensates for the higher IQ score(s) and Claimant therefore has mental retardation/intellectual disability. Low as his grades were, Claimant graduated from a public high school with a standard diploma, reflecting a sufficient level of adaptive functioning (meeting community standards of personal independence and social responsibility) prior to age 18. In his adult life, Claimant demonstrates sufficient adaptive functioning in that he manages to secure and maintain housing and food for himself and his brother, and personally manages the financial affairs of both of them. Although he does not drive, he is capable of navigating and travelling within the county using public transportation. Claimant does not now have mental retardation, nor did he before the age of 18 years.

15. Claimant has not established that prior to the age of 18 years, he had a "disabling condition . . . [that] require[ed] treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512, subd. (a).) No

evidence was introduced as to what treatment is required for individuals with mental retardation, or that Claimant needed similar treatment prior to the age of 18.

16. The testimony of Dr. Fischer persuasively established that Claimant does and did not prior to age 18 have mental retardation or a disabling condition that requires or required treatment similar to that required for individuals with mental retardation. His rising IQ test scores, the IQ test scores themselves, and other standardized academic testing administered to Claimant before he was 18 years old all reflect the profile of an individual with a learning disability (specifically in the area of mathematics), and with psychiatric disorders, but not mental retardation or a condition requiring similar treatment. Thus, he is not eligible under those categories.

17. Similarly, the evidence established Claimant is not eligible for services under the category of autism. None of the school records support a diagnosis of Autistic Disorder/Autism Spectrum Disorder, and the assessment performed on Claimant by the Service Agency in 2004 did not find him to be autistic. As reflected in Dr. Doi's Psychological Evaluation, Claimant does not exhibit the required symptomatology for autism. As reflected in Claimant's school records, Claimant would do anything to win acceptance, was imaginative, accepted blame and apologized readily, was conforming and obedient, and had a warm relationship with a teacher. Dr. Fischer explained that children with Autistic Disorder/Autism Spectrum Disorder could not be described in any of these ways. Claimant relies on a letter from Didi Hirsch Mental Health Services listing a diagnosis of Asperger's Disorder, however the assessment is unpersuasive. Dr. Doi's assessment more persuasively rules out Asperger's Disorder or any condition encompassed within Autism Spectrum Disorder. Moreover, Asperger's (as defined in the DSM-IV-TR), as opposed to Autistic Disorder (as defined in the DSM-IV-TR), has been held not to fall within the Lanterman Act's definition of a developmental disability.<sup>6</sup> Thus, the evidence demonstrated that Claimant was not eligible under the category of autism.

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<sup>6</sup> In light of the recent publication of the DSM-5, it has not yet been determined whether all severity ratings of Autism Spectrum Disorder (which includes what had previously been identified as Asperger's Disorder) qualify under the Lanterman Act's definition of a developmental disability.

ORDER

Claimant's appeal is denied.

DATED: October 24, 2013

  
KARA K. HATFIELD  
Administrative Law Judge  
Office of Administrative Hearings

NOTICE

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