

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of:

CLAIMANT,

and

INLAND REGIONAL CENTER

Service Agency.

OAH No. 2015030577

DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California (OAH), heard this matter in San Bernardino, California, on August 13, 2015.

Claimant's parents, his legal guardians, represented claimant, who was not present at the fair hearing.

Stephanie Zermeño, Consumer Services Representative, Fair Hearings and Legal Affairs, represented the Inland Regional Center (IRC).

The matter was submitted on August 13, 2015.

ISSUE

Is claimant eligible for regional center services under the Lanterman Act as a result of a diagnosis of autism spectrum disorder?

FACTUAL FINDINGS

Jurisdictional Matters

1. On January 13, 2015, IRC notified claimant that he was not eligible for regional center services.

2. In February 2015, claimant's parents filed a fair hearing request, appealing from IRC's decision. After the hearing was continued several times to permit claimant to undergo additional testing, this matter was heard on August 13, 2015.

Diagnostic Criteria for Autism Spectrum Disorder

3. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)*, identifies diagnostic criteria necessary to reach the diagnosis of Autism Spectrum Disorder. The diagnostic criteria include: persistent deficits in social communication and social interaction across multiple contexts; restricted, repetitive patterns of behavior, interests, or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of function; and disturbances that are not better explained by intellectual disability or global developmental delay. An individual must have a *DSM-5* diagnosis of autism spectrum disorder to qualify for regional center services.

Evidence Presented At Hearing

4. Claimant is a six-year-old male. He asserted that he was eligible for regional center services on the basis of autism spectrum disorder. He previously received Early Start services at IRC. Thereafter, he received services in Pennsylvania when his family relocated there while his father attended law school. The family has now moved back to California.

5. Claimant's IRC Early Start IFSP (Individualized Family Service Plan) documented that claimant received Early Start services from IRC due to developmental delays. Nothing in that document established claimant's eligibility for Lanterman Act regional center services.

6. A School Neuropsychological Evaluation was performed in Pennsylvania when claimant was four years, nine months old. It noted that claimant was referred for evaluation at his parents' request to determine his eligibility for special education and related services. The report contained summaries of the parents' reports about claimant's behaviors, issues, and medical history. Various assessments were performed including a Behavior Assessment System for Children, Second Edition (BASC-2) and the Childhood Autism Rating Scale, Second Edition (CARS-2). The report of evaluation indicated that claimant "completed the self-report-adolescent form" and that his scores were compared to "females his age." However, these references were clearly erroneous. The parents' scores on the BASC-2 suggested that claimant had severe emotional and behavioral issues and adaptive deficits when compared to males of a similar age. The parents' report suggested that claimant's social skills, somatization, and attentional functioning were at risk, and that there were significant levels of internalizing and externalizing behaviors that were maladaptive. Testing for attention and hyperactivity noted that claimant was distracted and engaged in more eye-opening and vocalizations than children of a similar age, and that he showed clinically significant characteristics of Attention Deficit Hyperactivity Disorder (ADHD).

The report stated that claimant had “many skills and strengths that will be overshadowed by his poor emotional and behavioral regulation deficits.”

The report further stated,

In addition, given that he has carried a diagnosis of autism spectrum disorder over the years, the parents were also asked to complete the CARS-2, which examines levels of characteristics often associated with [autism spectrum disorder]. Based on their ratings across multiple spheres of life, [claimant] appears to show severe levels of autism with a T-score in the above expected level. This means when compared to other children with autism spectrum disorder, [claimant] will appear severe in his symptomatology. On the other hand, the evaluator observed [claimant] in the office during a non-structured play situation with his mother present. Based on the observations during this period of time, very little symptoms of an autism spectrum disorder were perceived. Based on examiner ratings, [claimant] appears to not meet symptom criteria for an [autism spectrum disorder] with a T-score falling in the below expected level. It is possible that the parents perceive the symptoms more often in the home or community settings and on this particular day that [claimant] did not show as many problems of the disorder. It is also possible that the symptoms endorsed by the parents on the CARS-2 are indicative of another neurodevelopmental disorder such as ADHD, Combined Presentation. Often on the BASC-2, the areas associated with an [autism spectrum disorder] would include functional communication deficits, withdrawal, and social skills deficits. However, these areas were rated average to at risk based on peer ratings, thus, his symptom profile is somewhat still uncertain. The etiology of his behavioral symptoms may be due to separate factors (i.e., the birth process-NICU), due to another medical diagnosis such as ADHD, or due to other familial or environmental factors such as the two sustained [traumatic brain injuries]. His behavioral profile could also be indicative of combined effects from multiple sources that have eventuated over time.

The report stated that, “as he grows, he should continually be evaluated to determine the appropriateness of the [autism spectrum disorder] diagnosis.” The DSM-5 diagnostic impressions were found to be autism spectrum disorder by history, without accompanying intellectual impairment, without accompanying language impairment; attention deficit/hyperactivity disorder, combined presentation. Claimant’s primary Individuals with Disabilities Education Act (IDEA) classification and eligibility was other health impairment

(vision disorder, asthma/allergies, a sensory processing disorder, two sustained traumatic brain injuries, ADHD-C). The secondary IDEA classification was autism. The intervention strategies and recommendations sections of the report commented on the “nebulous nature of [claimant’s] current diagnoses and the complexity of his medical issues.” Further the report warned that the evaluation did not assess for pragmatic language skills, but was based on the parents’ ratings in the area of functional communication that did not rise to the level of at risk or clinically significant. The report noted that the new DSM-5 provided a new diagnosis identified as Social Pragmatic Communication Disorder. That disorder is given in lieu of an autism spectrum disorder diagnosis when all the criteria for autism spectrum disorder are not met. For children who only show difficulties in the social use of verbal and nonverbal communication and do not demonstrate repetitive, restricted patterns of behavior, the Social Pragmatic Communication Disorder diagnosis is often given. The report also noted that claimant evidenced an impulsive response style and did not have executive control of fine motor movements yet. It was believed he would benefit from a psychiatric evaluation to further explore any disabling psychological conditions, with the recommendation of medication and management to assuage symptoms of ADHD. The report concluded that claimant required more frequent assessment and reevaluation to assess his growth and improvement.

7. A Pennsylvania Early Intervention Process: Evaluation Report documented claimant’s reevaluation when he was 51 months old. The history section of the report stated that claimant was initially evaluated in Pennsylvania “in January 2014, at the chronological age of 29 months as part of the transition process from infant-toddler services.”¹ The history section reported that according to that evaluation, delays of 25 percent or greater were found in the areas of self-help/adaptive, communication and social/emotional development. Claimant had received early intervention services at 18 months, when his family resided in California. He was currently receiving the following preschool special education services: 30 minutes a week of special instruction (itinerant teacher services); 45 minutes a week of speech therapy; two 45-minute sessions of occupational therapy a week; 10 hours a week of Personal Care Assistant; and two two-hour sessions a week of behavioral specialist consultant services. In 2012 claimant was diagnosed with Pervasive Development Disorder (PDD) by one provider and with PDD, sensory disorder and behavior problem in child by another. Other than these references in the history section of this report, no other support for these diagnoses was introduced in this hearing. The history section of the report also noted that claimant was diagnosed with Post Concussive Syndrome following a motor vehicle accident occurring in 2013. His parents were continuing to seek treatment and evaluations for his vision, post-concussive symptoms, and other medical issues.

The family information section of the report stated that claimant did not attend preschool, but participated in a child care program at the YMCA. He went to church with the family three hours each week. He had nightmares and irregular sleeping patterns after the car accident. His parents reported that he was impulsive and showed minimal concept of consequences for impulsive behavior. He showed aggression to family members and

¹ However, in January 2014 claimant would have been 41 months old.

himself. His parents reported that claimant was a bright and inquisitive boy who enjoyed learning. In the health summary section, it was reported that genetic testing was normal. It was reported that claimant's PDD symptoms began two years before and were expected to last two years. His symptoms were moderate and occurred constantly. Aggravating factors were unknown, but relieving factors included therapies. Claimant's symptoms were poorly controlled and had increased since the car accident. He also experienced "a big decline in his vision." He reportedly regressed in speech and continued to be extremely hyperactive. It was reported that claimant only slept about five hours per night "which is likely contributing to his behavior and hyperactivity." Claimant was unable to handle school, his behaviors had become much worse, and he was being homeschooled with therapies and wraparound services at home. He continued to complain of headaches following the car accident. It was reported that claimant had a lazy eye and while he wore corrective lenses, his amblyopia was not corrected and his vision was not 20/20 with corrective lenses. He continued to treat with the Eye Institute.

The cognitive development section of the report noted that claimant was "demonstrating age-appropriate cognitive skills; however, it is very difficult to gain and sustain his attention, as well as motivate him to engage with non-preferred activities." The social and emotional development section of the report noted that claimant showed a range of emotions, laughed at silly actions, and smiled to show his pleasure during favorite activities. He exhibited occasional outbursts of anger, initiated play conversation with the therapist, and had learned to wait his turn following verbal prompts. His strengths were identified as being "lovable, shows excitement for pleasurable activities." He protested having to engage in unwanted behaviors by using words such as "stupid" or "I hate you."

The adaptive development section noted that claimant's major strengths rested in his interest and motivation to learn. He was very detail oriented and loved to learn about concepts that were very advanced for his age. When he engaged in a preferred activity, he could be fully immersed in that activity for up to 30 minutes at a time. While he exhibited some extreme emotional behaviors, claimant showed remorse for his actions once he calmed down. Further, when he was calm, he responded well to social stories or games that addressed coping techniques and self-regulation.

The psychological observation conducted in the home on December 18, 2013, noted that claimant was constantly in motion and his mood swings ranged from highs to lows during the brief period of observation. He constantly required instruction, redirection, and reinforcement from adults to maintain safe behavior, complete tasks, and follow directions. He was eager to share information, often interrupted adults to ask questions or share information he found to be important, and demonstrated an ability to express himself with relative ease. He engaged in many sensory activities that challenged him to maintain focus and attention. He tended to try to control situations, and often resisted when adults exerted their authority, but with careful phrasing of words, he could be prompted to complete adult directives. He was extremely impulsive and, at one point, threw the occupational therapist's box of materials across the room, past his mother's face and towards the psychologist's face. He did not hit anyone, but he seemed very surprised at what he had just done. The autism

spectrum rating scales portion of the report noted that the scores were based upon claimant's parents' responses. Claimant had many difficulties and exhibited many autism spectrum disorder features. One of his strengths was his "desire to interact with others."

8. A Pennsylvania Individualized Family Service Plan (IFSP) Individualized Education Plan (IEP) mentioned that claimant was referred for services in December 2011. The 2014 itinerant teacher's update noted that claimant responded well to social stories about emotions and social play. He provided answers when asked questions relating to how the people in the pictures were feeling and why they may have been feeling that way. Claimant could express his feelings and state his emotions, but he usually exhibited an emotional behavior at the same time. He continued to exhibit occasional outbursts of anger, but those behaviors decreased over time during therapy sessions. Claimant provided a lot of details about topics of interest and his strength was that he was an inquisitive learner; however, he needed help to sustain his attention to tasks. The vision update indicated that he continued to be seen by a pediatric optometrist and wore glasses full-time. He was receiving consultative vision support services. The behavior specialist consultation report noted his strengths were his eagerness to learn new information, his emerging academic and pre-reading skills, his advanced vocabulary, his sense of humor and likability, and his strong family and church supports. His needs were consistent support, modeling of appropriate use of advanced vocabulary and thinking skills, and consistent routines. The social participation section stated that "it is difficult to separate sensory sensitivity from other influences such as behavior, social/emotional, or increased activity/decreased attention differences." In the evaluation section, it was noted that claimant "exhibited decreased attention, increased activity and required redirection." It was recommended that his sensory needs be addressed through his preschool special education occupational therapy program. He had functional strength and muscle tone but the manner in which his muscles responded to movement was on the low side of normal. However, these deficiencies did not prevent him from participating in educational activities.

Nothing in the report indicated that claimant had a diagnosis of autism spectrum disorder.

9. A February 7, 2014, report from St. Christopher's Pediatric Associates in Pennsylvania was performed by Joanne Bailey, OD, who documented claimant's evaluation for eye turn in his right eye that started three years ago. The chief complaint and history of present illness section of the report documented claimant's history of amblyopia, eye patching, using atropine and wearing glasses. He was involved in two motor vehicle accidents and had concussions in 2011 and 2013. It was noted that he had autism spectrum disorder, PDD NOS and sensory processing disorder, but the report did not indicate the basis for that history. The impression section of the report noted: unspecified pervasive developmental disorder, sensory processing disorder, and autism, but again no basis for that impression was noted.

10. A Comprehensive Biopsychosocial Re-Evaluations conducted in Pennsylvania in January and April 2014 documented claimant's medical history, the records that were

reviewed, and the parents' report. The evaluator also interviewed claimant. The DSM-IV Diagnosis sections in the reports stated Axis I: Asperger's Disorder; Axis II: deferred; Axis III: Complicated at Birth, vision difficulties, head injury in March 2013, food allergies, sensory issues (auditory and temperature); Axis IV: stressors related to diagnosis, family stressors; Axis V: GAF-50. The April 2014 report noted that claimant was diagnosed with Asperger's Disorder in February 2013, but how that diagnosis was derived was unclear. Moreover, the assessor interview contained in the January 2014 report was insufficient to support a diagnosis of autism spectrum disorder. The April 2014 report noted that claimant continued to exhibit delays in his social skill development with poor frustration management skills. He continued to show physical aggression towards others, especially his brother, and displayed poor focus and impulsivity. Claimant had experienced "significant progress" in all areas with therapy except in the areas of Sleep Problems and Attention Problems. Claimant still eloped and there were safety concerns. It was recommended that claimant's behavioral services remain in place.

11. On February 12, 2014, Marianne San Antonio, D.O., in the division of developmental medicine at a hospital in Delaware, noted the current concerns were that claimant was previously diagnosed with an autism spectrum disorder and had recent concussions and behavioral difficulties. The report noted that claimant was diagnosed with an autism spectrum disorder a year ago. Again, the basis for that statement and/or diagnosis was not established. The parents had reported that they observed a skills loss after the first car accident September 2011, that sleep patterns had worsened, and that claimant was lining things up more often. Claimant exhibited more mood changes since the most recent car accident in March 2013.² Under the social assessment section of her report, Dr. San Antonio noted that claimant had difficulty making and maintaining friendships but was interested in his peers. He was reported to have spinning and hand flapping. He engaged in self-injurious behavior, had no sense of danger, and engaged in aggressive behavior. There was a maternal family history of ADHD and autism spectrum disorder with two paternal cousins, as well as other emotional/mental health issues.

Claimant's parents reported difficulties with attention, impulsivity and hyperactivity. Dr. San Antonio agreed with the diagnosis of an autism spectrum disorder, based on claimant's history of difficulties with the social use of language, difficulty with consistently using nonverbal communication strategies, difficulty with repetitive play and maintaining friendships, as well as demonstrating a number of restricted and repetitive behaviors. However, nothing in Dr. San Antonio's report indicated that she performed any testing to confirm that diagnosis. Claimant was also reported to be having many recent mood changes and frequent tantrums, as well as sleep disruptions. Although some of his daily behavioral difficulties may have been influenced by lack of sleep, some of these changes also worsened after a recent concussion. He was also believed to be at higher risk of experiencing mood difficulties given his family history. Dr. Antonio opined that claimant should continue

² Reports indicated that the motor vehicle accident in 2011 occurred when claimant's mother struck a deer and the 2013 motor vehicle accident occurred when claimant's vehicle was rear-ended.

receiving therapies and supports, that his supports should include supports specific to children with autism spectrum disorders. There was no diagnostic testing performed or documented, and Dr. San Antonio's impression/diagnoses appeared to be based only on the parents' self-report, her observations during the examination, and her review of prior records.

12. Numerous records documenting claimant's visual condition and his history and treatment of that condition were introduced. These records did not establish his eligibility for regional center services. Although some reports referenced claimant's history of "Asperger's Syndrome" and "PDD NOS," no support for those references was provided. Moreover, the reports often interchanged the use of these terms for claimant's diagnoses. As IRC asserted, the diagnoses given were often incompatible; for example PDD and autism. This use of so many different diagnoses without any testing to establish them lent further support to IRC's determination that these diagnoses had been loosely proscribed to claimant

13. Records documenting claimant's concussive syndrome from the two motor vehicle accidents were introduced. These records did not establish claimant's eligibility for regional center services.

14. A July 6, 2012, consultation assessed claimant with Pervasive Developmental Disorder, active; behavior problem in child; and sensory disorder.

15. Several e-mails between claimant's parents and treaters contained claimant's mother's report of claimant's condition and issues.

16. Reports documenting claimant's speech therapy, physical therapy, and occupational therapy outlined the services claimant has received. As his parents explained, these intensive services have greatly aided claimant.

17. Records from medical providers at St. Christopher's Pediatric Associates stated that claimant's assessment was unspecified pervasive developmental disorder, sensory disorder, and behavior problem in child. However, these assessments appear to have been based on parent reports and physician observations; no specific autism testing was noted. Additionally, claimant's neurologist wrote in 2012 that claimant "does show signs concerning for pervasive developmental disorder," but his opinion about "signs concerning" was insufficient to establish claimant's eligibility for regional center services. The neurologist also noted claimant's difficulty with sensory processing.

18. The ASQ-3 and ASQ-SE summaries did not establish claimant's eligibility for regional center services.

19. On May 20, and 27, 2015, The Autism Center performed an Autism Behavioral Health Treatment Functional Behavior Assessment. The report contained diagnoses of autism spectrum disorder, ADHD, and powerful wave seizures. The report appeared to be based on parent reporting and observation during the assessment. Claimant received scores in the low and average ranges. The assessment observations section noted

that claimant exhibited behavioral rigidity throughout the assessment, such as frequently asking the assessor and his mother to be quiet because he was trying to watch his TV shows. Claimant became agitated and upset frequently throughout the observation. When it was time for the assessor to leave, claimant became upset, vocally expressing discontent with not being able to socialize with the assessor as much as he wanted. Claimant also became agitated with his mother when she elaborated on what he deemed to be his “bad behavior.” The assessor noted the claimant was “extremely sociable and enjoys interacting with the adults around.” The assessor noted that claimant would benefit from intensive applied behavioral analysis (ABA) treatment to address his current social communication impairments and restricted/repetitive patterns of behavior.

The assessor’s observations appear to be at odds with the diagnosis of autism spectrum disorder given the social behavior the assessor described.

20. The DSM-5 criteria for autism spectrum disorder and attention-deficit/hyperactivity disorder were introduced and referenced in the witness testimony.

IRC Evaluation and Testimony

21. IRC Staff Psychologist Sandra Brooks, Ph.D., performed the IRC eligibility evaluation of claimant. She authored a report and testified in conformity with that report at this hearing. October 21, 2014, Dr. Brooks performed a psychological assessment. She administered several tests, observed claimant, spoke with his teacher and school psychologist, and interviewed his parents. On June 9, 2015, she conducted a home observation. She also reviewed claimant’s records. Based upon her evaluation, Dr. Brooks determined that claimant was not eligible for regional center services.

Claimant’s teacher reported that claimant demonstrated exceptional interactive play skills and did not have difficulty with social interaction. The teacher reported that claimant had a good understanding of consequences and was able to explain why he is denied a privilege. Claimant thrived on positive feedback. The school psychologist³ reported that claimant attempted to lead children in play, initiated interaction, and was very aware of his surroundings and how children were acting around him. The school psychologist reported that claimant did not demonstrate restricted interests, or repetitive or stereotyped behaviors. Dr. Brooks noted during her observation, claimant was very friendly and engaging, and that he demonstrated shared enjoyment. He made frequent plays for Dr. Brooks’s attention and for the attention of his parents; he was frustrated or disappointed when he did not receive attention. Claimant was demonstrative and used gestures spontaneously and effectively. He

³ Claimant’s parents testified that they did not recognize the name of the school psychologist and that they knew all of claimant’s school providers, so they doubted this input. However, their unfamiliarity with the school psychologist was insufficient to invalidate the school psychologist’s statements or Dr. Brooks’s reliance on them. Moreover, and as noted in Dr. Brooks’s report, the school psychologist provided very detailed information regarding her observations of claimant at school.

demonstrated good social awareness, was able to identify when he had done something wrong, and apologized for his actions. In the home setting, Dr. Brooks observed claimant recover quickly from poor feelings and return to playing interactively with others. She did not observe any clear evidence of restricted interests or repetitive behavior. Claimant offered information about but did not persevere concerning any particular topic. Dr. Brooks observed that claimant was very impulsive and highly distractible. School personnel and Dr. Brooks observed that claimant possessed a highly advanced vocabulary and that he appeared to play with toys appropriately. Although his parents reported sensory issues, the teacher and school psychologist did not observe any hypersensitivity. The teacher reported that claimant was highly inquisitive, asking lots of questions.

Based upon her observations and the reports from school personnel, Dr. Brooks concluded that claimant does not meet the criteria for an autism spectrum disorder diagnosis. He appears to have a number of behavioral issues in the home setting, but in the school setting he was described as being sociable and empathic towards peers and adults. He does not demonstrate significant deficits in social communications, has no restricted interests or repetitive behaviors, and is able to talk about preferred topics in a detailed manner that is commensurate with his level of intelligence. He demonstrated an ability to adapt to changes in the school setting and his level of social interest and awareness was inconsistent with a diagnosis of autism spectrum disorder. Given claimant's parents' reports of elevated levels of inattention, hyperactivity and impulsivity, some of which were observed during Dr. Brooks's evaluation, she opined that further evaluation may be warranted to rule out ADHD.

At this hearing, Dr. Brooks testified that claimant was ineligible for regional center services, based upon her personal assessment and review of records. Dr. Brooks credibly explained that claimant's behaviors were not due to a developmental disability. Dr. Brooks pointed out the many other psychological diagnoses and factors that better explained claimant's behaviors, especially ADHD. Dr. Brooks performed a careful and thorough analysis of claimant and claimant's records, and her determination that claimant did not qualify for regional center services was valid, reasonable, and well supported.

Parents' Testimony

22. Claimant's parents testified about their son's condition, explaining their observations and his numerous difficulties. Their testimony was heartfelt and sincere. However, it did not establish claimant's eligibility for regional center services. Moreover, it ultimately lent further factual support to Dr. Brooks's opinions.

//

//

LEGAL CONCLUSIONS

Burden of Proof

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, § 115.)

Statutory Authority

2. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

3. Welfare and Institutions Code section 4501 states:

The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .

An array of services and supports should be established 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. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), defines “developmental disability” as follows:

“Developmental disability” means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this 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 mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

5. California Code of Regulations, title 17, section 54000, provides:

(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 Developmental 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.

6. 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 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.

(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.

Evaluation

7. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet to qualify for regional center services. None of the documents introduced in this hearing demonstrated that claimant has a valid diagnosis of autistic spectrum disorder. Although some records referenced that diagnosis, no supporting testing was obtained to reach or support that diagnosis. It appeared that claimant may have simply been given the “diagnosis” without a thorough workup similar to the one IRC conducted. Claimant’s sensory deficits and probable ADHD appear to be the actual cause of the issues his parents have reported and not an autistic spectrum disorder. Finally, claimant’s social skills documented in the reports, such as his ability to empathize, understand other’s feelings, and make statements intended to hurt other’s feelings, are simply incompatible with a diagnosis of autistic spectrum disorder.

Although claimant’s parents questioned Dr. Brooks’s opinions because she did not consult with any of claimant’s previous treaters, claimant had the burden of proof in this matter. Claimant failed to provide sufficient evidence to demonstrate his eligibility to receive regional center services. Thus, his appeal of IRC’s determination that he is ineligible to receive services must be denied.

ORDER

Claimant’s appeal from Inland Regional Center’s determination that he is not eligible for regional center services and supports is denied. Claimant is ineligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act.

DATED: August 25, 2015

_____/s/_____
MARY AGNES MATYSZEWSKI
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 ninety days.