BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Eligibility of: CLAIMANT, and SAN DIEGO REGIONAL CENTER, Service Agency.	OAH No. 2016121009

DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California (OAH), heard this matter in El Centro, California, on February 15, 2017.

Neil Kramer, M.S., Fair Hearing Manager, represented the San Diego Regional Center (SDRC).

Claimant's mother and father represented claimant.

The matter was submitted on February 15, 2017.

ISSUES

1. Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) as a result of a diagnosis of Autism Spectrum Disorder and/or Intellectual Disability that constitutes a substantial disability?

2. Should SDRC perform additional testing on claimant?

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FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. On November 14, 2016, SDRC notified claimant that he was not eligible for regional center services.

2. On December 22, 2016, claimant's mother filed a fair hearing request, appealing SDRC's decision.

3. Claimant's mother stated in claimant's Fair Hearing Request:

> In my opinion not all factors of my son's . . . mental history were evaluated thoroughly, only focusing on ADHD and ASD symptoms even though the [school district] performed special education testing, I believe their [*sic*] should have been more testing at SDRC to compare differences between them. Furthermore on the evaluation their [*sic*] was no statement about him hearing noises, not sleeping well almost every night requiring a night light and poor fine motor skills. Also, the psychologist might have been biased because she has children that [*sic*] have ADHD. Would like to have another psychiatrist reevaluate him and perform more thorough testing. I recommend Susan Gehrig Paradox.

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDER

4. 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.

DIAGNOSTIC CRITERIA FOR INTELLECTUAL DISABILITY

5. The DSM-5 also contains diagnostic criteria used for a diagnosis of Intellectual Disability. Three diagnostic criteria must be met: Deficits in intellectual functions, deficits in adaptive functioning, and the onset of these deficits during the developmental period. Intellectual functioning is typically measured using intelligence tests. Individuals with Intellectual Disability typically have Intelligence Quotient (IQ) scores in the 65-75 range. An individual must have a DSM-5 diagnosis of intellectual disability to qualify for regional center services.

BACKGROUND

6. Claimant is an eleven-year-old male. Claimant was an Early Start client of SDRC beginning in 2008 due to speech delay. He did not receive further regional center services after age three. SDRC determined claimant was not substantially disabled due to a developmental disability in September 2008, and SDRC then notified claimant he was not eligible for on-doing regional center services.

7. Claimant has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). He has been treated for that condition with medication by Pria Persuad, M.D., Staff Psychiatrist, Imperial County Behavioral Health Services. Dr. Persuad has not diagnosed claimant with Autism Spectrum Disorder or Intellectual Disability.

8. Claimant's school district determined in May 2016 that claimant was not eligible for special education because standardized academic assessment showed he

was progressing academically, and he was within the average to above average range in all composite areas. The school district determined claimant qualified for reasonable accommodations under Section 504 of the Rehabilitation Act of 1973 based on concerns regarding lack of focus and writing and penmanship difficulties. As a result, his school provides the following accommodations: Extended time for assignment completion, peer tutoring, shorter assignments, graphic organizers and visual aids, study sheets, frequent checks for understanding, preferential seating, use of an assigned planner, additional allowances to ask for clarification, and directions given in a variety of ways.

Claimant has been enrolled in private tutoring and in the KUMON program to assist him with his learning.

THE PSYCHOLOGICAL EVALUATIONS

July 2008 Evaluation

9. SDRC referred claimant for an evaluation with Christine L. Trigeiro, Ph.D., in 2008. Dr. Trigeiro conducted her testing and evaluation on July 17, 2008, when claimant was two years and nine months old. She obtained background information from claimant's parents and SDRC's written Regional Center Social Summary, and she observed claimant.

Dr. Trigeiro's written Psychological Evaluation noted her behavioral observations:

> David ran quickly and without hesitation down the hallway, heedless of where his mother was. When he entered the test room, he quickly sat down at a small table to play with toys. He enjoyed playing with an animal pop-up toy and he independently operated the knobs and levers. He needed no assistance in putting blocks into a shape sorter toy. Transition was made to test activities. [Claimant] was

> cooperative with test activities. He was sometimes impulsive in his actions, but he generally waited for instructions or questions. He made good eye contact with the examiner and he smiled when he was praised. During the evaluation, David jabbered and said a few words. Significant articulation errors and omissions often made it difficult to understand him. He used pointing to augment his communication, such as pointing toward the door to indicate that he had a similar object at home. After direct testing was over, David played appropriately with an assortment of small figures, animals and vehicles. No behavior problems were noted.

Dr. Trigeiro conducted intelligence testing using the Wechsler Preschool and Primary Scale of Intelligence – 3rd Edition (WPPSI-III). Claimant received a full scale IQ score of 92, with a Verbal IQ score of 97 and a Performance IQ score of 90. His scores were in the average range and his verbal and performance scores were not significantly different from each other.

Based upon claimant's parents' responses to questions about his adaptive skills, claimant received an Adaptive Behavioral Composite of 83 on the Vineland Adaptive Behavior Scales – II. His estimated abilities in different areas were as follows:

	Standard Score	Age Equivalent Range
Communication	84	1 yr. 11 mo. to 2 yr. 2 mo.
Daily Living Skills	89	1 yr. 6 mo. to 2 yr. 8 mo.
Socialization	80	1 yr. 6 mo. to 1 yr. 9 mo.
Motor Skills	90	2 yr. 3 mo. to 2 yr. 6 mo.

Dr. Trigeiro's diagnostic impressions were that claimant had "Average cognitive functioning," "Phonological (Articulation) disorder," and "Expressive language delay." His

overall cognitive functioning was in the average range and his adaptive skills were in the moderately low range. Dr. Trigeiro's report noted:

> He has adequate skill levels for his age in self-care and household activities, fine and gross motor skills and receptive communication. He has moderately low abilities in expressive communication, which affects his social skill development. Some resistance, impatience and irritability are also reported and may have some impact on his social interactions as well.

Dr. Tigeiro recommended claimant would benefit from "a well-structured preschool program that can provide stimulation and information in developing group learning skills, play skills and speech and language skills" and a "comprehensive speech and language evaluation."

May 2016 Evaluation

10. Yvonne M. Camillo, M.S., School Psychologist, conducted an Initial Psychoeducational Evaluation in May 2016, when claimant was ten years, six months old and attending elementary school. Claimant was referred for assessment by the school's Student Study Team (SST) based on the following:

> [Claimant] demonstrates poor fine motor skills and has difficulty with attention/focusing. He has a diagnosis of ADHD. Behaviors of concern include isolating himself during independent work by wrapping his arm over his head, repetitive tapping, going under his desk to tap on desk leg, and reluctance to follow explicit directions. Based upon the

> referral information, the area of suspected disability was Specific Learning Disability, Other Health Impairment, and Autism.
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> Interventions previously attempted in an effort to maintain [claimant] in the regular program include: Contact between parent and school, SST monitoring, use of iPad for written work, prompts to stay on task, explaining procedures/expectations individually, preferential seating, shortened assignments, extended time for assignments, praise/reward, use of graphic organizers, peer assistance. The interventions described above have not facilitated [claimant's] adequate performance within the regular education program.

The Initial Psychoeducational Evaluation Report summarized claimant's educational history and noted that he had shown satisfactory progress during elementary school from kindergarten through fifth grade, although he struggled with penmanship. He was in fifth grade at the time of the assessment, and "noted to be a hard worker, puts forth effort, and enjoys reading." On STAR Reading and Math assessments in August 2015 he achieved grade equivalents of 5.3 in Math and 6.9 in Reading. The evaluation noted claimant's 2012 ADHD diagnosis and stated that at the time of the evaluation he was prescribed Adderall for ADHD symptoms.

The report provided the following behavioral observations:

> During the assessment session [claimant] presented as a neatly dressed and groomed Hispanic young boy. [Claimant] wore his glasses throughout the assessment session, and is

noted to regularly wear his glasses in the classroom setting. His nails were very short as though he bites his nails. He was a bit reserved at first and initially made little eye contact. However, as testing progressed, [claimant] seemed more comfortable and his eye contact improved. No repetitive/stereotypical motor movements were observed. Overall, [claimant] was very pleasant and cooperative, as he freely engaged in conversation with the examiner. [Claimant] appeared to be interested in the assessment procedures. His attention span during the evaluation was good. His concentration was average and his vigilance was good. His motivation for successful completion of the testing was good. His persistence on difficult tasks was good and his effort throughout the testing was good.

[Claimant] was observed in his general education classroom on 4/18/2016 during an independent vocabulary lesson. Students were to locate vocabulary words in a dictionary and copy down the definition. [Claimant's] desk is located in the front row on the west of the classroom. [Claimant] often stood while working. [Claimant] flipped through the pages of his dictionary but did not write anything down. He often looked at his peers' work next to him. [Claimant] eventually asked a female peer seated next to him for assistance in locating a word in the dictionary. Once the word was located he began to write the definition. [Claimant] rubbed his hands over his hair on three occasions and appeared a bit anxious.

> He worked with his head down for a few seconds. Students were then verbally instructed to clean up and prepare to be dismissed for recess. Students were informed they would review math upon returning from recess. [Claimant] cleaned up his desk and walked out to recess. [Claimant] played wall ball during recess, however he was not very engaged in the game. Several students were using the same wall and [claimant] stood towards the back of the group waiting for the ball to approach him. He appeared to enjoy the game as he smiled and laughed. He briefly interacted with a male peer. The ball came towards [claimant] and he grabbed it and threw it back at the wall. He then returned to standing towards the back. Overall, [claimant] appeared to be more of a bystander than actually engaging in the game. He occasionally commented on the game with nearby male peers.

The Wechsler Intelligence Scale for Children – Fifth Edition (WISC-V) was administered to evaluate claimant's cognitive intelligence. Claimant's full scale composite IQ score was 94, in the average range. His scores on the other cognitive scales measured were within the average and low average ranges as follows:

Scale	Composite Score	Qualitative Description
Verbal Comprehension	108	Average
Visual Spatial	92	Average
Fluid Reasoning	97	Average
Working Memory	85	Low Average
Processing Speed	89	Low Average

The report noted that Woodcock-Johnson IV Tests of Achievement (WJ-IV) had been administered by the special education teacher in April 2016, and claimant's total achievement score was in the average range. The Berry-Buktenica Developmental Test of Visual-Motor Integration, 6th Edition (VMI-6) was used to measure claimant's eye-hand coordination. The result was within the low average range. The Comprehensive Test of Phonological Processing – 2nd Edition (CTOPP-2) was used to assess claimant's awareness and access to the phonological structure of oral language. Claimant scored in the various quotients of that test in the low average, average, and above average ranges.

To assess claimant's adaptive and social behavior, Ms. Camillo used the Behavior System for Children, Second Edition (BASC-2), and the Gilliam Autism Rating Scale, Third Edition (GARS-3), based on information provided by claimant's parents and his fifth-grade teacher. The report referenced the results of the BASC-2, as follows: On the Parent Rating Scales – Child (PRS-C), areas of clinical significance were hyperactivity, aggression, conduct problems, and activities of daily living, and areas of risk were atypicality, attention problems, adaptability, social skills, and functional communication; on the Teacher Rating Scales – Child (TRS-C), the areas of clinical significance were atypicality, and the areas of risk were attention problems, learning problems, withdrawal, social skills, leadership, and functional communications. On the GARS-3, based on the parents' answers, claimant's Autism Index score was 87, signifying the "probability of ASD" as "Very Likely." Based on claimant's teacher's answers, the Autism Index score was 69, signifying the "Probability of ASD" as "Probable."

The report concluded that claimant was not eligible for special education and that claimant's learning problems were not due to Intellectual Disability. The report noted that while the GARS-3 reflected "Very Likely" and "Probable" for Autism Spectrum Disorder, and claimant "displays characteristics often associated with autism, these

characteristics are not severely impacting his academic performance." The report also stated:

> [Claimant] has been diagnosed with ADHD. However, it appears that his academic achievement has not been significantly impacted by difficulties with attention and concentration based on academic assessment. Standardized academic assessment indicates [claimant] has been progressing academically, such that he indicated knowledge within the average to above average range in all composite areas. Hence, [claimant's] academic progress has not been adversely affected by limited strength, vitality, or alertness. As such, [claimant] does not qualify for special education services under the category of Other Health Impairment (OHI).

The evaluation recommended that claimant continue in the regular, general education setting and referred the parents to SDRC to further explore the possibility of Autism Spectrum Disorder.

September 2016 Evaluation

11. Eriko Lapoint, Psy.D., conducted a Psychological Evaluation of claimant for SDRC on September 26, 2016, when claimant was 10 years, 11 months, and 28 days old. Dr. Lapoint did not conduct additional cognitive testing because claimant had recently been assessed at school, and there were "no expressed concerns about his cognitive functioning and he has consistently performed at the average range." Dr. Lapoint interviewed claimant and his mother and administered the Childhood Autism Rating Scale – Second Edition High Functioning Version (CARS2-HF). The ratings on that scale

are based on the frequency, intensity, peculiarity, and duration of behaviors and are derived through the practitioner's observation of the child during testing. Claimant scored in the "minimal" to "no symptoms" of Autism Spectrum Disorder range.

Dr. Lapoint's report summarized her observations of claimant as follows:

> [Claimant] did not look up to me as I spoke to him and reluctantly walked with me to the evaluation room. [Claimant] presented as a withdrawn, aloof individual. He struggled to answer basic questions about himself and mostly responded with "I don't know" or one-word responses. [Claimant's] speech was mostly clear although he spoke rapidly, sometimes mildly interfering with the intelligibility of his words. There was appropriate variability in his intonation with no unusual patterns of speech or idiosyncrasies. His tone toward his mother was mostly angry and loud, with frequent use of sarcasm. In response to my questioning, he often made avoidant responses such as "I've been asked that so many times," or "I just don't like talking about it so much" . . . .
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> Today, [claimant] did not engage in any unusual repetitive interests or sensory seeking behaviors. He was reluctant yet did not demonstrate difficulty transitioning topics or activities although no significant demands were placed on him.

Dr. Lapoint's report stated that it was her diagnostic impression that claimant suffers from Attention Deficit Hyperactivity Disorder, Combined Type, and he does not

meet the diagnostic criteria for Autism Spectrum Disorder. Dr. Lapoint's report further noted:

> Parent reports of early history supported by psychological reports describing his behaviors indicate that [claimant] was a fairly typical child who shared interests, enjoyed social relationships, demonstrated joint attention behaviors, and was responsive to others. Currently, his psychiatrist does not see symptoms of ASD. It appears that a behavioral shift occurred around 4th or 5th grade, causing a marked change from a cheerful, engaged child to one with emotional discord, anger, and anxiety, particularly on the home front. . .

HARRY EISNER, PH.D.'S EXPERT OPINION TESTIMONY

12. Harry Eisner, Ph.D., holds a doctorate in psychology and has been a licensed clinical psychologist in California for over 30 years. He is SDRC's Coordinator of Counseling Services and has worked for SDRC for the past 28 years, assessing the eligibility of claimants for regional center services. He has evaluated tens of thousands of claimants over the course of his 28-year career at SDRC.

Dr. Eisner opined that claimant is not eligible for regional center services. He based his opinion on claimant's academic history, the psychological evaluations conducted by SDRC in 2008 and 2016, the psychoeducational evaluation conducted by the school psychologist in 2016, and on information provided to him during the informal meeting between SDRC and claimant's family.

Dr. Eisner explained that when making a diagnosis of Autism Spectrum Disorder, a practitioner is looking for behavior in three areas: Social, language, and a "third category." In the social area, an autistic person may be totally uninterested in social

interactions or awkward in social situations. According to Dr. Eisner, a practitioner would not need to observe the behavior very long to notice it. In the area of language, an autistic person may display atypical language development, which is not the same as language delays. In the "third category," the autistic person may engage in obsessive compulsive behaviors, have emotional regulation issues, and/or sensory sensitivity. Dr. Eisner noted that normally you would see these types of behaviors every day in an autistic child and they may be quite disruptive. Dr. Eisner did not see indications of atypical behaviors in claimant in the social, language, or third category areas that would be consistent with a diagnosis of Autism Spectrum Disorder.

Dr. Eisner described claimant as a shy, nervous child who had delays in language development when he was little. Now that claimant is eleven, he is still shy and nervous, and he may be more aloof. Claimant is still anxious, fearful, and attentive to noises. Claimant is interested in other children, although he may be more of an observer than a participant with other children. He is more comfortable with people he knows, and he does better in situations when he is with people he knows. Dr. Eisner described these issues as mild differences that do not indicate autism. According to Dr. Eisner, claimant appeared to be a child who may be irritable, but not "odd."

Dr. Eisner noted that no one has diagnosed claimant with Autism Spectrum Disorder.

Additionally, Dr. Eisner opined that he would not diagnose claimant as suffering from an Intellectual Disability. This opinion was based on claimant's IQ scores, which were consistent in 2008 and 2016, with full scale IQ scores in the average range. Dr. Eisner pointed out that claimant has been doing okay academically in general education at public school, although his is impulsive and disorganized.

Dr. Eisner explained that it was not necessary to conduct additional cognitive tests at the time of Dr. Lapoint's September 2016 evaluation because the school had

recently conducted cognitive tests in May 2016, less than six months earlier. Those measures are usually stable, and it would be highly unusual for the scores to drop in less than one year unless the child suffered some sort of a head injury.

CLAIMANT'S MOTHER'S TESTIMONY

13. After SDRC finished presenting its evidence, Mr. and Ms. Longoria initially indicated they did not have any further evidence to present. However, Ms. Longoria did briefly testify. She described every day with her son as a bad day. She said if a routine is changed, he will have a bad day. Everything is a constant battle, as claimant is argumentative and has tantrums.

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.)

2. "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' [Citations.] . . . . The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) "If the evidence is so evenly balanced that you are unable to say that the evidence on either side of an issue preponderates, your finding on that issue must be against the party who had the burden of proving it [citation]." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 663.)

STATUTORY AUTHORITY

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

4. 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.
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> [¶] . . . [¶]
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> 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. . . .

5. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as follows:

"Developmental disability" means a disability that originates before an individual attains 18 years of age; 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 intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

6. California Code of Regulations, title 17, section 54000[1], 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:

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[1] The regulation still uses the former term "mental retardation" instead of "intellectual disability."

(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.

7. 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.

8. Welfare and Institutions Code section 4642, subdivision (a), requires a regional center to perform initial intake and assessment services for "any person believed to have a developmental disability." Welfare and Institutions Code section 4643, subdivisions (a) and (b), provide regarding assessment services:

(a) If assessment is needed, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client

would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b).

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

EVALUATION

9. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet to qualify for regional center services. None of the evidence introduced in this hearing demonstrated that claimant has Autism Spectrum Disorder or that he has an Intellectual Disability. SDRC properly considered its prior 2008 assessment and the evaluations and tests conducted by the school district in 2016. Additional intelligence testing of claimant was not warranted, as it was appropriate for SDRC to rely on the recent intelligence testing performed by the school district during 2016, which resulted in scores that were consistent with the testing SDRC performed in 2008. As the evidence failed to demonstrate claimant suffers from Autism Spectrum Disorder or an Intellectual Disability, claimant is not eligible to receive regional center services. Thus, his appeal from SDRC's determination that he is ineligible to receive regional centerservices must be denied.

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ORDER

1. Claimant's request that SDRC perform additional testing on claimant is denied.

2. Claimant is ineligible for regional center services and supports under the Lanterman Developmental Disabilities Services Act.

3. Claimant's appeal from San Diego Regional Center's determination that he is not eligible for regional center services and supports is denied.

DATED: January 27, 2017

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THERESA M. BREHL

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.