BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

INLAND REGIONAL CENTER

Service Agency

OAH No. 2018061194

DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on June 3, 2019, and July 29, 2019, in San Bernardino, California.

Jennifer Cummings, Program Manager, Fair Hearings and Legal Affairs, represented Inland Regional Center (IRC).

Jeanie Min and Pilar Gonzalez Morales, Attorneys at Law, Disability Rights California, represented claimant, who was not present.

Oral and documentary evidence was received. The record was closed and the matter submitted for decision on July 29, 2019.

ISSUE

1. Is IRC's original determination finding claimant eligible for regional center services under a diagnosis of intellectual disability clearly erroneous in light of IRC's recent comprehensive reassessment?

2. Is claimant eligible for regional center services under the Lanterman Act based on the Fifth Category?

FACTUAL FINDINGS

Background[1]

1. Claimant is a seven-year old girl. Claimant lives with her mother and father, who are also her maternal grandparents, as well as three older siblings.[2] Claimant has a previous diagnosis of Fetal Alcohol Syndrome and was exposed to methamphetamine, cocaine, cannabis, tobacco, and alcohol in utero. Claimant received services from IRC under the Early Start program starting on April 21, 2014, due to

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[1] The information concerning claimant was compiled from various sources, including testimony of Ruth Stacy, Psy.D., and documentary evidence.

[2] Claimant's siblings also receive special education services, and have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

delays in communication, fine motor, and cognitive skills. Confidential consumer information notes described claimant as a "friendly energetic girl" who communicated with "gestures and facial expressions." It was also noted that claimant did not chew her food and engaged in self-injurious behaviors, like biting her fingers or purposely falling to the floor, when asked to do something she did not want to do.

2. According to claimant's April 21, 2014, Early Start Individualized Family Service Plan (IFSP), completed when claimant was 31 months old, claimant loved to dance and was independent in using a napkin to wipe her mouth. Claimant would put her dirty dishes in the sink. Claimant could drink from a straw; play with toys; and washed and dried her hands with assistance. Claimant would show strong periods of independence in social and emotional interactions. Claimant could turn pages of a book, release a raisin into a bottle, and place six pegs into a pegboard without assistance. Claimant was oriented to her name, looked at the appropriate person when that person was named, and inhibited her activity in response to being told "no." Claimant's gross motor skills were shown to be age appropriate.

3. According to claimant's August 28, 2014, Individualized Education Program Plan (IEP), claimant qualified for special education services under the category of intellectual disability. Claimant was placed in a moderate-severe special day class with services that included specialized academic instruction and speech/language therapy.

4. A September 11, 2014 IFSP progress report, completed when claimant was one-day shy of 36 months old, showed: claimant's cognitive development exceeded her chronological age (37 months); claimant's social-emotional development exceeded her chronological age (46 months); and claimant's expressive and receptive language skills were just about age appropriate (34 months old and 35 months old,

respectively). Claimant's fine and gross motor skills were shown to be the equivalent of a 29-month-old child.

5. On August 5, 2014, when claimant was just under three years old, Tracy Dern, Psy.D., conducted a psychological assessment to determine whether claimant was eligible for regional center services under the Lanterman Act. Dr. Dern conducted the Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition; the Vineland Adaptive Behavior Scales, reviewed claimant's records, and conducted a diagnostic interview. Following the assessment, Dr. Dern concluded claimant was in the borderline range in her adaptive skills and exhibited cognitive delays. Thus, she recommended eligibility under a "provisional diagnosis of intellectual disability" and also recommended that claimant be reassessed in three years.

6. On April 27, 2017, claimant's school district completed a Transition to Kindergarten report, which noted that claimant had good disposition in the classroom; was cooperative and fun to teach; had a good sense of humor; enjoyed interacting with teaching staff and peers; engaged in cooperative play; did well in small group activities; engaged in tasks with minimal re-direction; and was easily re-directed, when needed. The report also noted claimant was able to express her wants and needs and had good social skills.

7. On May 18, 2017, claimant's school district completed a Speech and Language Evaluation Report. The speech and language assessment was conducted over two days. The report noted claimant had "clear speech intelligibility" at the conversation level. Claimant's vocabulary skills were shown to be "slightly below average" and her oral and written language skills were shown to be average. Other observations noted in the report showed claimant's expressive and receptive language skills to be "age appropriate." The report then outlined the eligibility criteria for special

education eligibility under the category of speech and language impairment, as set forth in Title 5 of the California Code of Regulations. It is noted that Title 5 criteria for special education are much less stringent than eligibility criteria for regional center eligibility for persons with developmental disabilities under the Lanterman Act. The school determined that claimant did not meet the criteria for special education services because claimant had speech and language skills that were age-appropriate. The report further noted claimant functioned "well above" the level that would qualify a child for special education services in the category of speech and language impairment.

8. On June 5, 2017, following the determination that claimant did not meet the criteria for special education services under the category of speech and language impairment, the school conducted a Triennial Psycho-Educational Assessment of claimant. The school administered several measures, including the Vineland Adaptive Behavior Scales, Third Edition; the Beery Visual-Motor Integration test, Sixth Edition (VMI), and the Developmental Profile 3. The school also reviewed other psychological records, reviewed claimant's medical records, sought parent input, sought teacher input, and observed claimant.

Claimant exhibited "strength in the area of visual-motor integration" and tested in the average range. The Vineland tests adaptive skills, and is comprised of four domain scores, including communication, daily living skills, socialization, and motor skills, as well as multiple subsets within each domain. Claimant's scores varied widely. Claimant's scores were as follows: motor skills (moderately high); socialization (moderately high); daily living skills (adequate); and communication (adequate). Claimant's scores in the subsets within each domain included scores that were high, moderately high, and adequate. Claimant had only one "moderately low" score in

numeric expression. Overall, claimant's adaptive composite behavior score was determined to be moderately high.

Because an IQ test could not be administered (claimant is African American), the school report concluded claimant's cognitive skills are likely within the average range, based on her adaptive functioning levels. Accordingly, claimant did not qualify for special education under the category of intellectual disability, which, according to the report, required claimant to have "significantly sub-average intellectual functioning" concurrent with deficits in adaptive behavior.

9. On March 22, 2018, Ruth Stacy, Psy.D., conducted a comprehensive reassessment of claimant to determine whether she remained eligible for regional center services. Dr. Stacy administered the Wechsler Scale of Intelligence for Children, Fifth Edition; the Adaptive Behavior Assessment System, Third Edition; reviewed claimant's records; and conducted a diagnostic interview. Dr. Stacy concluded claimant did not meet the diagnostic criteria for intellectual disability, and diagnosed her with ADHD, which is not a qualifying disorder. Dr. Stacy's testimony and psychological assessment will be discussed more fully below.

10. On May 2, 2018, IRC's eligibility team, which was comprised of a medical doctor, Dr. Stacy, and a Program Manager, reviewed claimant's records and Dr. Stacy's psychological assessment. The IRC eligibility team concluded claimant was no longer eligible for regional center services.

11. On May 14, 2018, IRC sent claimant a Notice of Proposed Action stating that the original determination that claimant was eligible for regional center services under the diagnosis of intellectual disability is clearly erroneous in light of the comprehensive reassessment.

12. On June 25, 2018, claimant's mother filed a Fair Hearing Request challenging IRC's determination.

13. Leigh-Ann Pierce, a Program Manager at IRC, and claimant's father attended a telephonic conference on July 11, 2018, to discuss claimant's eligibility. Following the meeting, IRC adhered to its determination, and the matter was set for hearing. The letter also indicated claimant was not eligible under any other qualifying category.

14. In the ensuing months, the matter was continued eight times for various reasons, mostly, to permit claimant to obtain an additional assessment and/or documentation. Those documents included a psychological assessment report completed by Colette D. Sinclair, M.A., L.E.P. in December 2018, who did not testify at the hearing, did not provide a curriculum vitae, and who is not a licensed clinical psychologist. Thus, this report was given little weight in reaching this decision.

Also submitted was a March 13, 2019, Multidisciplinary Teacher's Report completed by claimant's school district that showed claimant did not meet the special education criteria for intellectual disability because, although her adaptive skills showed some challenges, her cognitive skills were too high. Most important, this report showed concluded claimant's cognitive and adaptive skills were consistent with ADHD, Combined Type, which is precisely what Dr. Stacy diagnosed claimant with in March 2019. Moreover, the report noted claimant suffered from a medical condition, encopresis (a bowel disorder). Thus, claimant qualified for special education services under the category of other health impairment due to her encopresis and ADHD.

Finally, a May 10, 2019, Neuropsychological Evaluation completed by Sarah Mattson, Ph.D., was also submitted. That assessment, discussed more fully below in Dr.

Mattson's testimony, concluded claimant suffered from a Fetal Alcohol Spectrum Disorder (FASD), which includes alcohol-related neurodevelopmental disorders (ARND). Dr. Mattson concluded claimant's ARND qualified claimant for regional center services under the fifth category because claimant had cognitive and adaptive challenges, and "would benefit" from treatment like the treatment given to those who have a diagnosis of intellectual disability.

15. On March 19, 2019, after reviewing new reports and assessments, IRC's eligibility team adhered to its original conclusion that claimant was not eligible for regional center services. On May 22, 2019, after receiving additional records, IRC again determined that claimant was no longer eligible for regional center services under the category of intellectual disability and did not qualify for regional center services under the fifth category.

16. At hearing, the issues that were presented were whether 1) the original determination that claimant qualified for regional center services is clearly erroneous in light of the comprehensive reassessment, and 2) whether claimant is eligible for regional center services under the fifth category.

Burdens and Standards of Proof

17. Claimant contended that, since IRC's May 15, 2018, Notice of Proposed Action identified that claimant is no longer eligible for services under any of the categories contained in the Lanterman Act (i.e. autism, epilepsy, intellectual disability, cerebral palsy, and the fifth category), IRC has the burden of proving that claimant is not eligible under either intellectual disability or the fifth category. However, claimant asserted that even if claimant is found to have the burden of proof with respect to the fifth category, claimant can prove she qualifies by a preponderance of the evidence.

18. IRC contended that claimant was eligible for regional center services under intellectual disability, and based on its comprehensive reassessment (which included review of all claimant's records), claimant no longer qualifies under that diagnosis. IRC does not dispute that it has the burden of proving by a preponderance of the evidence that its original determination is clearly erroneous. However, IRC contended that the assertion that claimant is eligible for regional center services under the fifth category is a new claim for eligibility, and thus, claimant has the burden of proof.

19. It is determined that IRC has the burden of proving by a preponderance of the evidence that its original determination finding claimant eligible for regional center services under the category of intellectual disability is clearly erroneous. As claimant was never eligible for regional center services based on the fifth category, eligibility under the fifth category is a new claim. Thus, claimant has the burden of proving by a preponderance of the evidence that she qualifies for regional center services under the fifth category.

Applicable Diagnostic Criteria

INTELLECTUAL DISABILITY

20. The Diagnostic *and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) contains the diagnostic criteria used for intellectual disability. The essential features of intellectual disability are deficits in general mental abilities and impairment in everyday adaptive functioning, as compared to an individual's age, gender, and socio-culturally matched peers. In order to have a DSM-5 diagnosis of intellectual disability, three diagnostic criteria must be met. First, deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, academic learning,

and learning from experience, must be present. Second, deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility, must be present. Third, the onset of the cognitive and adaptive deficits must occur during the developmental period.

Intellectual functioning is typically measured using intelligence tests. Individuals with intellectual disability typically have intelligent quotient (IQ) scores in the 65-75 range.

DIAGNOSTIC CRITERIA FOR GLOBAL DEVELOPMENTAL DELAY[3]

21. According to the DSM-5, this diagnosis is reserved for individuals under the age of five years when the clinical severity level cannot be reliably assessed during early childhood. This category is diagnosed when an individual fails to meet expected developmental milestones in several areas of intellectual functioning, and applies to individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing. This category requires reassessment after a period of time.

DIAGNOSTIC CRITERIA FOR ADHD

22. Sometimes, ADHD may be comorbid with a diagnosis of intellectual disability; or, it may exist separately. ADHD is a neurodevelopmental disorder defined by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity.

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[3] Neither GDD nor ADHD are qualifying diagnoses for regional center services. However, since Dr. Stacy discussed GDD and diagnosed claimant with ADHD, and both experts discussed ADHD, these diagnostic criteria are included.

Inattention and disorganization entail inability to stay on task, seeming not to listen, and losing materials, at levels that are inconsistent with age or developmental level. Hyperactivity-impulsivity entails overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and the inability to wait. ADHD often persists into adulthood, with resultant impairments of social, academic, and occupational functioning.

The DSM-5 diagnostic criteria for ADHD includes: persistent pattern of inattention and/or hyperactivity that interferes with functioning or development, as characterized inattention, hyperactivity, or both.

In order to meet the diagnostic criteria under inattention, a person must have six or more of the following symptoms that persist for at least six months in a manner that impacts social and academic/occupational activities: often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities; often has trouble holding attention on tasks or play activities; often does not seem to listen when spoken to directly; often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked); often has trouble organizing tasks and activities; often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework); often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones); is often easily distracted; and is often forgetful in daily activities.

In order to meet the diagnostic criteria under hyperactivity and/or impulsivity, a person must have six or more of the following symptoms that persist for at least six months in a manner that is inconsistent with his or her developmental level and negatively impacts social and academic/occupational activities: often fidgets with or

taps hands or feet, or squirms in seat; often leaves seat in situations when remaining seated is expected; often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless); often unable to play or take part in leisure activities quietly; is often "on the go" acting as if "driven by a motor"; often talks excessively; often blurts out an answer before a question has been completed; often has trouble waiting his/her turn; often interrupts or intrudes on others (e.g., butts into conversations or games).

In addition, the following conditions must be met: several inattentive or hyperactive-impulsive symptoms were present before age 12 years; several symptoms are present in two or more settings (home, school or work; with friends or relatives; in other activities); there is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning; the symptoms do not happen only during the course of schizophrenia or another psychotic disorder; and the symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

A diagnosis of ADHD Combined Presentation is appropriate if a person meets the criteria for both inattention and Hyperactivity/impulsivity.

DIAGNOSTIC CRITERIA FOR FIFTH CATEGORY

23. Under the fifth category, the Lanterman Act provides assistance to individuals with disabling condition closely related to an intellectual disability or that requires similar treatment as an individual with an intellectual disability but does not include other handicapping conditions that are "solely physical in nature." (Welf. & Inst. Code, § 4512, subd. (a).) A disability involving the fifth category must also have

originated before an individual attained 18 years of age, must continue or be expected to continue indefinitely, and must constitute a substantial disability.

In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that the fifth category condition must be very similar to intellectual disability, with many of the same, or close to the same, factors required in classifying a person as intellectually disabled. Another appellate decision has also suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with an intellectual disability, notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for intellectual disability. The court understood and noted that the Association of Regional Center Agencies had guidelines (ARCA Guidelines) which recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with intellectual disability.

The Association of Regional Center Agencies Guidelines (ARCA Guidelines) provide criteria to assist regional centers in determining whether a person qualifies for services under the fifth category. The ARCA Guidelines provide that the person must function in a manner similar to a person with an intellectual disability or who requires treatment similar to a person with an intellectual disability.

Functioning Similar to a Person with an Intellectual Disability

24. A person functions in a manner similar to a person with an intellectual disability if the person has significant sub-average general intellectual functioning that is accompanied by significant functional limitations in adaptive functioning. Intellectual functioning is determined by standardized tests. A person has significant sub-average intellectual functioning if the person has an IQ of 70 or below. Factors a regional center should consider include: the ability of an individual to solve problems with insight, to adapt to new situations, and to think abstractly and profit from experience. (ARCA Guidelines, citing Cal. Code Regs., tit. 22, § 54002.) If a person's IQ is above 70, it becomes increasingly essential that the person demonstrate significant and substantial adaptive deficits and that the substantial deficits are related to the cognitive limitations, as opposed to a medical or some other problem. It is also important that, whatever deficits in intelligence are exhibited, the deficits show stability over time.

Significant deficits in adaptive functioning are established based on the clinical judgements supplemented by formal adaptive behavioral assessments administered by qualified personnel. Adaptive skill deficits are deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains or by an inability to perform those tasks with adequate judgement. Adaptive skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse, or limited experience.

Treatment Similar to a Person with an Intellectual Disability

25. In determining whether a person requires treatment similar to a person with an intellectual disability, a regional center should consider the nature of training and intervention that is most appropriate for the individual who has global cognitive deficits. This includes consideration of the following: individuals demonstrating performance based deficits often need treatment to increase motivation rather than training to develop skills; individuals with skill deficits secondary to socio-cultural deprivation but not secondary to intellectual limitations need short-term, remedial training, which is not similar to that required by persons with an intellectual disability; persons requiring habilitation may be eligible, but persons primarily requiring rehabilitation are not typically eligible as the term rehabilitation implies recovery; individuals who require long-term training with steps broken down into small, discrete units taught through repetition may be eligible; the type of educational supports needed to assist children with learning (generally, children with an intellectual disability need more supports, with modifications across many skill areas).

Substantial Disability

26. The ARCA Guidelines also refer to California Code of Regulations, title 17, sections 54000 and 54001 regarding whether a person has a substantial disability. This means the person must have a significant functional limitation in three or more major life areas, as appropriate for the person's age, in the areas of: communication (must have significant deficits in both expressive and receptive language), learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

Dr. Stacy's Testimony

27. Ruth Stacy, Psy.D., testified on behalf of IRC. Dr. Stacy is a staff psychologist at IRC. She has also held positions at IRC such as Senior Intake Counselor, Senior Consumer Services Coordinator, and Consumer Services Coordinator. In all of those capacities, she dealt directly with individuals who either had or were suspected of having developmental disabilities, among other challenges. She has been involved in assessing individuals who desire to obtain IRC services under the Lanterman Act for over 29 years. In addition to her doctorate degree in psychology, she also holds a Master of Arts in Counseling Psychology, a Master of Arts in Sociology, and a Bachelor of Arts in Psychology and Sociology. Dr. Stacy qualifies as an expert in the diagnosis of intellectual disability, and in the determination of eligibility for IRC services based on intellectual disability and the fifth category. Dr. Stacy reviewed reports pertaining to claimant. Those reports included those identified previously in this decision. The following is a summary of Dr. Stacy's testimony and the documentary evidence.

Dr. Stacy correctly related the diagnostic criteria for both intellectual disability and the fifth category. She explained that for a diagnosis of intellectual disability, a person must have intellectual deficits, as typically measured by an IQ of below 75, before adaptive deficits are even considered. With respect to the fifth category, Dr. Stacy explained that as a person's IQ exceeds 70, it becomes increasingly important for that person's adaptive deficits to be very low, and it must also show that the adaptive deficits are attributable to the lower cognitive skills as opposed to something else. This is precisely why, in young children, they are very rarely qualified under the fifth category because their cognitive and adaptive skills are still developing. The test as to whether a person is eligible for regional center services under the fifth category is also not simply whether they can "benefit" from treatment or services provided by a

regional center; rather, it is whether they require treatment similar to a person with an intellectual disability.

Typically, when a child is diagnosed with Global Developmental Delay or provisionally qualified for regional center services under intellectual disability, IRC will reassess the child around age five. In claimant's case, she had a history of her mother using drugs and alcohol, being in foster care, being left at a "drug house," and many other negative factors. Nobody can really be sure what claimant was exposed to in her early developmental years. However, not every child exposed to such conditions or substances automatically equates with having an intellectual disability.

Claimant has been diagnosed by Dr. Mattson with FASD, or more specifically, ARND. The treatment options for these disorders is medication, which is not used to treat intellectual disability. Other treatments that may help or benefit persons with ARND are parent training, behavioral training, and specialized learning environments – none of which are exclusive to intellectual disability.

In claimant's early years, especially the records pertaining to when claimant was under three years old, there was a cognitive and adaptive delay present. However, Dr. Stacy explained that the delay appeared to be very mild (closer to a 33 percent). Thus, when Dr. Dern evaluated claimant, Dr. Dern felt claimant met the criteria for Global Developmental Delay, and claimant should be provisionally qualified for regional center services. Dr. Stacy did not disagree that claimant met the diagnostic criteria for Global Developmental Delay, but felt that since claimant's adaptive skills were not bad and her cognitive skills were in the borderline range, claimant should not have been qualified for regional center services under the category of intellectual disability. In other words, the qualification for services was erroneous.

Further, in reviewing the documents after claimant became eligible for regional center services, a diagnosis of intellectual disability or qualification under the fifth category is not warranted. Claimant's April 17, 2017, transition to kindergarten report, did not show any major concerns in either claimant's intellectual or adaptive skills. The May 18, 2017, Speech and Language Evaluation Report completed by claimant's school district determined claimant was functioning at an age appropriate level and did not qualify for special education services under speech and language impairment. Similarly, the June 5, 2017, Triennial Psycho-Educational Assessment showed claimant's cognitive skills were in the average range and her adaptive skills were moderately high. Thus, prior to Dr. Stacy conducting her March 22, 2018, psychological assessment, claimant did not present as a child who was either intellectually disabled or someone who exhibited substantial disabilities in three or more major life activities, as appropriate for her age.

Dr. Stacy conducted her psychological assessment on March 22, 2018. She utilized the Wechsler Scale of Intelligence for Children, Fifth Edition (WISC); Adaptive Behavior Assessment System (ABAS), and also conducted a diagnostic interview, observed claimant, and reviewed records. On the WISC, which tests cognitive functioning, claimant had a wide range of abilities. Overall, claimant's cognitive abilities fell within the low average range. As Dr. Stacy noted, however, low average skills are simply at the lower end of the "average" range. Thus, claimant was not functioning at a deficit. Claimant's scores on the ABAS showed her adaptive skills to range from extremely low to average. The ABAS is a form completed by claimant's parent or caregiver. Dr. Stacy noted that the unusually low results yielded on the ABAS appeared to be a gross underestimation of claimant's adaptive skills. The results of the ABAS were simply inconsistent with claimant's cognitive functioning, which was tested by using an objective measure. Dr. Stacy also concluded, because of her low average

cognitive abilities, claimant did not qualify for regional center services under the fifth category. Dr. Stacy diagnosed claimant with ADHD, Combined Presentation, and opined that claimant's adaptive challenges are attributable to her ADHD as opposed to any cognitive deficit.

Regarding the December 2018 report completed by Ms. Sinclair, Dr. Stacy explained that a licensed educational psychologist is not the same as a licensed clinical psychologist. A licensed clinical psychologist is a person licensed by the Board of Psychology. A licensed educational psychologist is a person with a master of arts degree, not a Ph.D., who obtains some additional training and becomes licensed by the Board of Behavioral Sciences. Dr. Stacy did not agree with the conclusion in Ms. Sinclair's report that claimant's cognitive and adaptive deficits were attributable to claimant's brain function.

Regarding the March 15, 2019, Multidisciplinary Report completed by claimant's school district, Dr. Stacy pointed out that, yet again, claimant's school concluded she did not meet the special education criteria for intellectual disability.

Dr. Stacy reviewed Dr. Mattson's May 10, 2019, psychological evaluation. She noted that claimant's scores on the WISC were very similar to when she administered the WISC just a few months prior. Again, there was a lot of variability among the different subsets, which is not consistent with a person who truly has an intellectual disability. Claimant's scores on the Vineland Adaptive Behavior Scales (Vineland) showed claimant had low adaptive skills, in fact, much lower than what she observed in her ABAS assessment. Dr. Stacy questioned the results of the Vineland because she noted it would not be normal for a person to regress in their adaptive skills in only two months. What would explain the variability, other than over-reporting adaptive challenges, is ADHD or some other factor. Intellectual functioning is not causing

claimant's adaptive challenges; a person with an intellectual disability sees consistent deficits over a long period of time. Claimant did not show that – even between when she conducted her assessment and when Dr. Mattson conducted her assessment. Finally, with respect to Dr. Mattson's evaluation, Dr. Stacy pointed out that in order to find claimant intellectually disabled, Dr. Mattson used 1.5 standard deviations below the normal expected cognitive functioning level as opposed to 2 standard deviations.

Dr. Stacy testified that the nature of training and intervention most appropriate for a person with intellectual disabilities is as follows: typically a person needs a lot of repetition broken down into small steps, a person doesn't necessary need mental health services; a person with true intellectual disability would need assistance in all areas of life - such as money management, making decisions, in getting employment; things would have to be modified for them to make it easier to understand; and they may have behavioral challenges. Intellectual disability is a substantial lifelong disability that is the result of cognitive limitations. For example, a person who is blind might benefit from the same treatment as a person with an intellectual disability (i.e. money management, cooking meals, etc.), but that would be because of their physical limitations not cognitive limitations. In that same vain, claimant may benefit from treatment similar to a person with an intellectual disability but it would not be because of her cognitive limitations, because claimant simply does not have the deficits expected of a person who is intellectually disabled.

Accordingly, even if claimant has ARND as diagnosed by Dr. Mattson, claimant no longer qualifies for regional center services under a diagnosis of intellectual disability and similarly does not qualify for regional center services under the fifth category.

Evidence Presented by Claimant

TESTIMONY OF DR. MATTSON

28. Dr. Mattson is currently a professor of psychology at California State University, San Diego (SDSU). She also serves as an adjunct professor at the University of California, San Diego, and is a co-director at the Center for Behavioral Teratology and enter for Clinical and Cognitive Neuroscience, both located at SDSU. Dr. Mattson holds a Ph.D. in Clinical Psychology with a Neuropsychology Specialty, an M.A. in Psychology, and a B.A. in Biology. She is licensed with the Board of Psychology. Dr. Mattson's clinical research experience is focused on alcohol-related neurodevelopmental disorders, and she has a current research grant in the field of Fetal Alcohol Spectrum Disorders (FASD). She also has had many prior grants in the area of pre-natal alcohol and drug exposure. Dr. Mattson is published in many peer-reviewed academic journals in the area of fetal alcohol and drug exposure, and has written chapters in books regarding the same. Dr. Mattson is an expert in the area of FASD.

Dr. Mattson conducted a neuropsychological evaluation of claimant on May 10, 2019, and completed a report. The following is a summary of her testimony and report.

As a neuropsychologist, Dr. Mattson's practice is to focus on how fetal alcohol exposure affects cognition and behavior. FASD is a diagnosis that encompasses people who may still show the cognitive effects of fetal alcohol exposure even though they lack the physical markers. It is a medical, as opposed to a psychological, diagnosis. ARND is included in the diagnosis of FASD. People with ARND are likely to have cognitive and adaptive deficits throughout their lifetime. Approximately 60 to 90 percent of people with ARND also have diagnoses of ADHD. Cognitive behavioral

impairment is determined if the person is 1.5 standard deviations below the normal range. People with ARND typically have higher intellectual functioning than a person with intellectual disability, so it is very common for them to not get services they need.

Dr. Mattson explained that the purpose of her assessment was to determine whether claimant met the diagnostic criteria for intellectual disability or the fifth category. She opined that ARND is similar to intellectual disability because ARND is characterized by significant impairment in cognitive and adaptive functioning. Based on her assessment, claimant probably does not meet the criteria for intellectual disability. However, some children with ARND have adaptive impairments that exceed cognitive impairments, which is the case with claimant. Treatments for FASD or ARND are also similar to treatments that a person with an intellectual disability would receive.

Dr. Mattson administered the following tests: WISC; the NEPSY II; NIH toolbox; Wechsler Individual Achievement Test, third edition (WIAT-3); California Verbal Learning Test (CVLT); Child Behavioral Checklist (CBCL); two versions of the Vineland Adaptive Behavior Scale, Third Edition (Vineland); Delis Rating of Executive Function (DREF); Behavior Rating Inventory of Executive Function, Second Edition (BRIEF 2); and the Behavior Assessment System for Children, Third Edition (BASC 3).

During the testing, Dr. Mattson observed claimant to be fidgety but "not overly inattentive." An assistant who was helping conduct the assessment noticed claimant "was easily distracted and needed to be redirected . . . ."

Claimant's full scale IQ score was determined to be 76. On the WISC, claimant scored in the low average to average range of cognitive abilities. These scores differed from her executive functioning scores on the NEPSY II, which showed claimant to be significantly challenged in the area of executive functioning.

On the Vineland, claimant's adaptive skills were shown to be significantly lower than her overall cognitive abilities. On the BASC 3, fewer than 5 percent of the children in the general population had scores as low as claimant. On the BRIEF 2, all scores were in the "clinically elevated" range. Concerns were noted with claimant's ability to resist impulses, be aware of her functioning in social settings, adjust well to changes in her environment, get going on tasks, and problem solving, among other things. Dr. Mattson explained that "these difficulties likely relate to fundamental behavioral and emotional regulation difficulties and suggest that more global problems with self-regulation are having a negative effect on active cognitive problem solving . . . ." On the D-REF, all of claimant's scores as determined by the parent reporting form showed difficulties in behavioral, emotional, and cognitive functions. The NIH Toolbox and CVLT showed claimant's memory to be "relatively intact" while her "verbal and visual memory" are impaired. On the WIAT-3, claimant's academic functioning was determined to be below average. On the CBCL, which was filled out by claimant's father, claimant was shown to have both behavioral and emotional problems.

Dr. Mattson provided an ARND checklist to claimant's father, which contained 35 items. Claimant's father checked off 2 items, which is above the cutoff and suggests impairment consistent with ARND. Items endorsed included "seems unaware of consequences of actions, socially inept, easily manipulated by others, and requires constant supervision."

Dr. Mattson provided an ADHD checklist to claimant's father, which contained 18 items relating to behaviors consistent with ADHD. Claimant's father checked off nine symptoms that cause moderate to severe problems at home and school and nine hyperactive/impulsive symptoms, which cause moderate to severe problems at home and school.

Dr. Mattson diagnosed claimant as follows:

> ARND is characterized by cognitive impairment or behavioral impairment. Cognitive impairment is defined as impairment at least 1.5 standard deviations (SD) below the norm on a measure of global ability or on tests of 2 other cognitive domains. Claimant has a FSIQ of 76 which is more than 1.5 standard deviations below the norm. She also demonstrated impairment more than 1.5 standard deviations from the norm on academic functioning . . . . While cognitive impairment supersedes behavioral impairment diagnostically, in the absence of documented cognitive impairment claimant would also meet the criteria for ARND based on her behavioral scores . . . .

Dr. Mattson concluded claimant has "many features consistent with FASD including a history of significant prenatal alcohol exposure, low IQ score, behavioral impairment, adaptive function deficits, and deficits in executive function, attention, and learning." Although claimant also likely met the criteria for ADHD, that condition "is not sufficient in and of itself to cause the difficulties she is having." In summary, Dr. Mattson concluded that the "most parsimonious explanation is that claimant's difficulties in learning, executive function, attention, overall cognition, problem behavior, and adaptive behavior are related to Fetal Alcohol Spectrum Disorder."

Dr. Mattson said that it is not appropriate to just diagnose claimant with ADHD, and ADHD is often a misdiagnosis from psychological professionals who do not have expertise in ARND or FASD. Dr. Mattson feels that ARND is a more global diagnosis that explains claimant's cognitive and adaptive deficits.

Dr. Mattson correctly identified the diagnostic criteria for the fifth category, and said it is her opinion that ARND is a condition similar to an intellectual disability because it "shares characteristics with intellectual disability and a person can benefit from treatment similar to" treatment provided to a person with an intellectual disability. For example, repeated exposure, alternative testing strategies, breaking things down into smaller steps, checklists, putting claimant in a smaller classroom, and helping to teach her better impulse control and safety awareness. Further, Dr. Mattson felt that even if one were to ignore the cognitive deficits, claimant's adaptive abilities are so low that she would still meet the criteria for the fifth category.

TESTIMONY OF CLAIMANT'S FATHER

29. Claimant's father testified at the hearing. The following is a summary of his testimony.

Claimant has been a regional center consumer since she was two years and eight months old. He is actually claimant's biological maternal grandfather, but adopted claimant when she was very young. Claimant lives with him and his wife, claimant's maternal grandmother, and three siblings, aged 12, 16, and 17. All three siblings have diagnoses of ADHD. Claimant's mother had a long history of issues with homelessness, drugs, and in general, her habits were not good. Claimant was adopted after being removed from her mother's care by social services.

A typical day for claimant begins waking up approximately 5:30 a.m. to have her ready for school. Getting claimant up is difficult. They structure claimant's activities such as dressing, brushing teeth, and having breakfast, so she can be ready for the bus. Claimant can eat by herself with supervision. She can use utensils. Claimant does play with her food and sometimes does not chew appropriately; instead, she shoves

huge pieces of food in her mouth. Claimant cannot bathe by herself. Claimant has encopresis and wears pull-ups, so she requires hourly changing.

When claimant gets home from school she is like the "energizer bunny." She literally runs all over the house. She goes to the kitchen and indiscriminately grabs whatever she wants. She runs around, having no direction in particular. It is very difficult to get her to settle down. It is as if she wants to do something she just doesn't know what she wants to do. Claimant will go into the family room and then the kitchen and start going through cabinets. When they try to calm claimant down, she will launch into full-blown tantrums.

Communication is difficult because claimant is driven by whatever is in her head at the moment you are speaking with her. Thus, claimant always has to have instructions repeated for her.

Claimant is currently in first grade. In the 2018-2019 school year, claimant was in the general education setting. She did not do well. As soon as she started in a general education class, the school was calling him almost daily because the general education teacher really had no clue how to deal with claimant. Sometimes claimant would engage in self-injurious behaviors at school, and exhibited behavioral issues. Claimant would take objects from the classroom, cut her hair, eat glue sticks, tear paper, take things apart and not put them back together, and disrupt the class. The school always characterized claimant as being uncooperative.

At home, claimant will tear up plants and eat the leaves. She is "harsh" with the family dogs. When out in the community, claimant will characterize everyone as her friend and thinks everyone likes her but whenever she engages with anyone it always becomes a problem. Claimant's father said they need to keep claimant on a tight leash.

At present, he receives financial assistance from the government since claimant is adopted, and those financial benefits will go down quite significantly if claimant is no longer an IRC consumer. Claimant does not receive any services from regional center. IRC did offer respite but he declined. IRC did offer behavioral services, but the providers would come into the home and their schedules did not work with the family schedule. It has always been a source of frustration that IRC is the "payor of last resort." Claimant's father said he does not really feel claimant needs any services at the moment, but feels she may need services in the future as she ages.

Claimant's father feels that ADHD is a "scapegoat diagnosis" for claimant and her three siblings and it is insulting when anyone suggests that they have ADHD when there is something out there that provides a more complete diagnosis.

Evaluation

30. IRC established by a preponderance of the evidence that its original determination finding claimant eligible for regional center services under a diagnosis of intellectual disability is clearly erroneous in light of the comprehensive reassessment conducted by Dr. Stacy, and other evidence presented at the hearing.

Claimant's August 28, 2014, IEP, September 11, 2014 IFSP progress report, and Dr. Dern's August 5, 2014, psychological assessment, showed claimant presented with some mild challenges in her adaptive and cognitive abilities. However, as claimant developed in age and abilities, her intellectual and adaptive functioning also developed, to a point where claimant was performing either at an age-appropriate range or very close to it. Claimant's April 17, 2017, transition to kindergarten report, did not show any major concerns in either claimant's intellectual or adaptive skills. The May 18, 2017, Speech and Language Evaluation Report completed by claimant's school

district determined claimant was functioning at an age appropriate level and did not qualify for special education services under speech and language impairment. Similarly, the June 5, 2017, Triennial Psycho-Educational Assessment showed claimant's cognitive skills were in the average range and her adaptive skills were moderately high. Thus, prior to Dr. Stacy conducting her March 22, 2018, psychological assessment, claimant did not present as a child who was either intellectually disabled or someone who exhibited substantial disabilities in three or more major life activities, as appropriate for her age.

Dr. Stacy, an expert in determining whether a person qualifies for regional center services either under the DSM-5 diagnosis of intellectual disability or the fifth category, and under the additional substantial disability criteria of the Lanterman Act, conducted a comprehensive assessment on March 22, 2018. Dr. Stacy's assessment showed claimant's cognitive abilities were higher than the level required for intellectual disability, and although claimant's adaptive skills were low, the low result likely flowed from the over-reporting of adaptive challenges on the ABAS. She opined claimant's adaptive skills were much higher than what was reported on the ABAS, and based on claimant's cognitive abilities, her adaptive abilities had to be higher. Finally, regardless of what adaptive challenges claimant had, they were more likely attributable to ADHD as opposed to cognitive limitations.

Following IRC's May 2, 2018, determination finding claimant was not eligible for regional center services, additional documents were submitted. Those documents included a psychological assessment report completed by Ms. Sinclair in December 2018, who did not testify at the hearing and who is not a licensed clinical psychologist. A March 13, 2019, multidisciplinary teacher's report completed by claimant's school district showed claimant did not meet the criteria for intellectual disability, as her

cognitive skills were too high, although her adaptive skills showed she was somewhat challenged. Of the utmost importance, this report showed claimant's cognitive and adaptive skills to be consistent with ADHD, Combined Type, which is precisely what Dr. Stacy diagnosed nearly three months prior. Moreover, the report noted claimant suffered from a medical condition, encopresis. Thus, claimant qualified for special education services under the category of other health impairment due to her encopresis and ADHD.

Dr. Mattson conducted extensive cognitive and adaptive testing to determine whether claimant met the criteria for the fifth category. Dr. Mattson agreed that claimant did not meet the criteria for intellectual disability. Dr. Mattson's background and experience, though very impressive and definitely well-published in the area of FASD and ARND, is not in the area of assessing eligibility for regional center services under the Lanterman Act. Dr. Mattson's battery of tests showed claimant to have cognitive abilities similar to what Dr. Stacy found; her cognitive abilities were in the low average to average range. Claimant's IQ was 76. This meant, in order for claimant to be eligible under the fifth category, her adaptive scores would have to be much lower. Claimant's adaptive skills on Dr. Mattson's tests were very low, however, it is noted that many of the adaptive scores are determined by parental reporting. As Dr. Stacy explained, it is not normal for a person to have such a huge change in adaptive scores in just a few months (i.e. between the time claimant tested with her and the time claimant tested with Dr. Mattson). Further, while ARND and FASD might be more comprehensive diagnoses for claimant's global problems, and nobody is disputing those diagnoses, FASD is a medical diagnosis and ARND falls under the FASD umbrella. In that respect, ARND is not a condition similar to an intellectual disability.

In sum, the weight of the evidence shows claimant does not meet the criteria for intellectual disability because cognitively, claimant functions in the average to low average range, and although her adaptive skills are lower, they are not reflective of her overall adaptive abilities. In other words, there was insufficient evidence that claimant's adaptive challenges are the result of cognitive deficits.

CONDITION CLOSELY RELATED TO INTELLECTUAL DISABILITY

31. ARND is not listed as an associated feature or disorder of intellectual disability in the DSM-5. That prenatal damage due to maternal alcohol consumption may be a predisposing factor or cause cognitive challenges does not necessarily imply that ARND is a condition closely related to an intellectual disability. According to Dr. Mattson's testimony, a child who suffers from ARND may benefit from services provided to a person with an intellectual disability. However, this is not the test as to whether the condition is similar to an intellectual disability. ARND falls under the larger spectrum of FASD, which is a medical diagnosis. Further, it was acknowledged that many individuals who suffer from ARND exhibit average or borderline intellectual functioning, which does not render it a condition closely related to an intellectual disability.

Accordingly, it is concluded that claimant does not suffer from a condition closely related to intellectual disability.

TREATMENT SIMILAR TO A PERSON WITH AN INTELLECTUAL DISABILITY

32. Claimant also does not qualify for services under the fifth category because she does not suffer from a condition that requires treatment similar to an intellectual disability.

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. Welfare and Institutions section 4512 elaborates further upon the services and supports listed in a consumer's individual program plan as including "diagnoses, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services,…" (Welf. & Inst. Code, § 4512, subd. (b).) The designation of "treatment" as a separate item is clear indication that it is not merely a synonym for services and supports.

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

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual's condition has many of the same, or close to the same, factors required in classifying a person as intellectually disabled. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119.) Furthermore, the various additional factors required in designating an individual as

developmentally disabled and substantially handicapped must apply as well. (*Id*. at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to intellectual disability and requires similar treatment. (*Id*. at p. 1130; *Samantha C. v. State Department of Developmental Services, supra,* 185 Cal.App.4th 1462, 1485.) Thus, the *Mason* court determined: "it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of 'developmental disability' so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (*Id*. at p. 1129.)

In this case, two experts testified. Both experts were exceptionally qualified in their fields, and both experts had a firm grasp of the evidentiary record. Dr. Stacy concluded claimant does not qualify for regional center services under the fifth category; Dr. Mattson disagreed.

In resolving any conflict in the testimony of expert witnesses, the opinion of one expert must be weighed against that of another. In doing so, consideration should be given to the qualifications and believability of each witness, the reasons for each opinion, and the matter upon which it is based. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reason upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

The testimony in this case by Dr. Stacy with respect to fifth category eligibility is determined to be more persuasive. Dr. Stacy is a licensed clinical psychologist with

extensive experience in assessing and evaluating individuals for the presence of developmental disabilities, eligibility under the fifth category, and the Lanterman Act in general. Dr. Stacy believes that claimant's deficits in adaptive functioning arise from ADHD. Claimant's reported behavioral issues appear to be directly related to ADHD. Dr. Mattson does not dispute claimant has ADHD, but feels ARND is a more comprehensive global diagnosis and claimant would benefit from treatment similar to treatment given to a person with an intellectual disability. Dr. Mattson may be 100 percent correct; claimant would benefit from treatment. However, many individuals – developmentally disabled or not – would benefit from treatment similar to treatment given to a person with an intellectual disability. Insufficient evidence in this case showed claimant **requires** treatment similar to a person with ADHD.

Finally, it is not enough to have a condition similar to an intellectual disability or that requires treatment similar to an intellectual disability. A person must also have substantially disabling limitations. Thus, even assuming claimant met the diagnostic criteria for the fifth category, which she does not, the evidence did not show that claimant has **significant functional limitations** in three or more major life activities, as determined by the regional center, and as required by the California Code of Regulations.

This is a case where deference should properly be given to IRC professionals in determining continuing eligibility and eligibility. (*Mason v. Office of Administrative Hearings*, *supra*, 89 Cal.App.4th 1119, 1129.) Accordingly, claimant's appeal must be denied.

LEGAL CONCLUSIONS

Applicable Law

1. The Legislature enacted a comprehensive statutory scheme known as the Lanterman Developmental Disabilities Services Act (Welf. & Inst. Code, § 4500 et seq.) to provide a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.) Welfare and Institutions Code section 4501 outlines the state's responsibility for persons with developmental disabilities and the state's duty to establish services for those individuals.

2. The department is the public agency in California responsible for carrying out the laws related to the care, custody and treatment of individuals with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code, § 4416.)

3. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq. Welfare and Institutions Code section 4501 provides:

> 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 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." A developmental disability includes "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Ibid.*) Handicapping conditions that are "solely physical in nature" do not qualify as developmental disabilities under the Lanterman Act. (*Ibid.*)

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

(a) "Developmental Disability" means a disability that is attributable to intellectual disability[4], cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability.

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(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-

[4] Although the Lanterman Act has been amended to eliminate the term "mental retardation" and replace it with "intellectual disability," the California Code of Regulations has not been amended to reflect the currently used terms.

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 intellectual disability, 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 intellectual disability."

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.

7. Welfare and Institutions Code section 4643.5, subdivision (b), provides:

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

Conclusion

8. IRC established by a preponderance of the evidence that its original determination finding claimant eligible for regional center services under a diagnosis of intellectual disability is clearly erroneous in light of the comprehensive reassessment conducted by Dr. Stacy, and other evidence presented at the hearing.

9. A preponderance of the evidence did not establish that claimant is eligible for regional center services under the fifth category.

ORDER

1. Claimant's appeal from Inland Regional Center's decision that its original determination finding claimant eligible under intellectual disability is clearly erroneous in light of the comprehensive reassessment is denied.

2. Claimant's appeal from Inland Regional Center's determination that claimant is not eligible for regional center services under the fifth category is denied.

DATE: August 12, 2019

KIMBERLY J. BELVEDERE
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.