BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

VS.

FRANK D. LANTERMAN REGIONAL CENTER

OAH No. 2019080986

DECISION

Carla L. Garrett, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on January 28, 2020, and March 11, 2020, in Los Angeles, California.

Jeffrey A. Gottlieb, Attorney at Law, represented Claimant.[1] Jessica T. Franey, Attorney at Law, represented the Frank D. Lanterman Regional Center (Service Agency or FDLRC).

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on March 11, 2020.

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[1] Titles are used to protect the privacy of Claimant and his family.

ISSUE

Is Claimant eligible to receive services and supports from the Service Agency under the Lanterman Developmental Disabilities Services Act (Lanterman Act)?

EVIDENCE

Documents: Service Agency's Exhibits 1 through 8; and Claimant's Exhibits A through L.

Testimony: On behalf of Service Agency, Caroline Garrabedian, Michele Johnson, Lorenzo Hernandez, and Dr. Jennifer Martinez; on behalf of Claimant, Dr. Carrie Dilley, Mother, and Sister.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Claimant is a 36-year-old man who was referred to the Service Agency by his mother (Mother) and older sister (Sister) who contend Claimant has Autism Spectrum Disorder (ASD).

2. On July 1, 2019, the Service Agency sent a letter to Claimant deeming him ineligible for regional center services. The Service Agency asserted Claimant did not present with a developmental disability, as defined by Welfare and Institutions Code section 4512, subdivision (a), and California Code of Regulations, title 17, section 54000, subdivisions (a) and (c). Specifically, the Service Agency concluded that the results of assessments performed on Claimant were consistent with the diagnoses of

Paranoid Personality Disorder (Premorbid) and Antisocial Personality Disorder—Deferred, and not a diagnosis of ASD, Intellectual Disability, Epilepsy, Cerebral Palsy, or a condition which requires treatment similar to that required by individuals with Intellectual Disability.

3. On August 6, 2019, Claimant filed a Fair Hearing Request to appeal the Service Agency's decision and to request a hearing. This hearing ensued.

School Records

4. Claimant attended Roosevelt Middle School from 1995 to 1997, and graduated with a 1.5 grade point average (GPA), ranking 449 out of 524 students. Claimant attended John Burroughs High School from 1998 to 2002, and graduated with a 1.29 GPA, ranking 418 out of 418 students. Claimant also received Special Education services, though neither party proffered any Independent Education Programs (IEP) pertaining to Claimant. Claimant attended community college for approximately 18 months before dropping out.

Progress Note of Dr. Jeffrey N. Grant

5. On May 4, 2012, Jeffrey N. Grant, M.D., met with Claimant who presented with depression. Dr. Grant noted that Claimant had a proven learning disorder, which made community college difficult for him, but Claimant complained of feeling tired, anxious, sleeping more, and experiencing trouble getting out of bed in the morning. Dr. Grant administered the Hamilton rating scale to test for depression, and diagnosed Claimant with depression. Dr. Grant opined Claimant was more frustrated than depressed, and recommended Claimant seek counseling and to return to community college to pursue his degree.

Progress Notes of Dr. Keith E. Valone

6. On September 24, 2018, Clinical Director of The Arroyos Psychological Associates, Keith E. Valone, Ph.D., Psy.D., M.S.C.P., met with Claimant and administered a Structured Clinical Interview (SCID) for the Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), which is a semi-structured interview guide for making major DSM-5 diagnoses. Dr. Valone evaluated Claimant for the presence of psychosis or other symptoms of Schizophrenia Spectrum Disorder, as Claimant had been diagnosed with the disorder previously, and prescribed with an antipsychotic. Dr. Valone reviewed Claimant's history and noted Claimant had been diagnosed with Major Depressive Disorder, Persistent Depressive Disorder, Social Anxiety Disorder, and Generalized Anxiety Disorder. He had also been diagnosed with one or more Specific Learning Disorders. Dr. Valone stated there was "also the question of an autism spectrum disorder, as the severe deficits in social behavior are not explained by any of the diagnoses obtained thus far." (Ex. I, p. 1.) Dr. Valone referred Claimant to Dr. Dilley for additional psychological testing to assess for ASD, among other things.

Neuropsychological Assessment by Dr. Carrie Dilley

7. On October 15, 29, 30, and November 5, 2018, Carrie N. Dilley, Ph.D., who has served as a licensed clinical psychologist since March 11, 2009, performed a neuropsychological assessment of Claimant, and prepared a written report. Dr. Dilley testified at hearing. Dr. Dilley earned her bachelor's degree in psychology, cum laude, from the University of Mississippi in 2001, and her masters' degree and doctorate in psychology from Fuller Theological Seminary, Graduate School of Psychology, in 2006 and 2007, respectively.

8. Dr. Dilley explained that while she is a clinical psychologist, she is not certified as a neuropsychologist; yet, she has received all of the requisite neuropsychology training to conduct neuropsychological assessments. Specifically, from 2001 through 2004, Dr. Dilley attended the Fuller Graduate School of Psychology: Assessment Sequence & Experience and received training on test administration of neuropsychological assessment batteries, as well as on the Wechsler Adult Intelligence Scale—Third Edition, Wechsler Intelligence Scale for Children—Third Edition, Thematic Apperception Test, Minnesota Multiphasic Personality Inventory, Rorschach, and other tests.

9. Since 2009, Dr. Dilley has been the co-owner of Synergy Psychological Inc., a private practice group that specializes in neurodevelopmental disabilities including ASD, Attention-Deficit Hyperactivity Disorder (ADHD), learning disabilities, impulse control disorders, and sensory processing disorders. In 2008, Dr. Dilley underwent a two-day certified training of the Autism Diagnostic Observation Schedule (ADOS) at Western Psychological Services. Since then, Dr. Dilley has conducted 80 to 85 ADOS assessments, and has made a number of presentations in the areas of ASD assessment, ASD diagnosis, ASD treatment, neurodevelopmental disorders, and more. Dr. Dilley has performed hundreds of assessments for regional centers and for special education purposes.

10. Dr. Valone referred Claimant to Dr. Dilley for a comprehensive psychological evaluation for further diagnostic clarity regarding Claimant's cognitive, academic, behavioral, and social functioning. In particular, Dr. Valone requested diagnostic clarification regarding the presence of behaviors possibly indicative of ASD, a specific learning disorder, and ADHD. Dr. Dilley administered the Achenbach Adult Behavior Checklist, including a self-report, and a parent/caregiver report completed by

Sister; Autism Diagnostic Observation Schedule, Second Edition, Module 4 (ADOS-2, Module 4); Beck Anxiety Inventory (BAI); Beck Depression Inventory, Second Edition (BDI-II); Beery-Buktenica Developmental Tests of Visual-Motor Integration, Sixth Edition (VMI-6); clinical record review of Dr. Keith Valone's progress notes and the Cedars Sinai Neuropsychological Evaluation (2009); clinical interview of Claimant, Mother, and Sister; Integrated Visual Auditory Continuous Performance Test, Second Edition (IVA-2); Neuropsychological Assessment, Second Edition (NEPSY-II); Trail Making Test A & B; Vineland Adaptive Behavior Scales, Second Edition (VABS-II); Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV); Wechsler Individual Achievement Test, Third Edition (WIAT-III); and the Winnie Dunn Adolescent/Adult Sensory Profile.

11. Dr. Dilley reviewed a neuropsychological assessment conducted at Cedars Sinai Medical Center on April 29, 2009 to assess Claimant's cognitive functioning, given the reported difficulty Claimant had with learning, academics, and maintaining steady employment. The records indicated Claimant identified a variety of concerns related to his academic abilities, especially language and math, his memory, his motor and coordination abilities, his sensory processing abilities, and behavior or mood problems. Claimant reported moderate symptoms of depression and anxiety, and stated he angered easily and had become more emotional. The testing results identified a discrepancy within Claimant's cognitive abilities, as he exhibited mostly average verbal and nonverbal abilities, and lower scores on tasks assessing his working memory and processing speed abilities. Claimant's academic performances ranged from borderline to average, and results included varied attention abilities. Claimant was diagnosed with a learning disorder, not otherwise specified, for the discrepancy between his visual abilities, as well as a developmental writing disorder. Dr. Dilley

noted symptoms related to ASD were not assessed during this evaluation, and the assessment included no psychological diagnoses specific to Claimant's mental health.

12. Dr. Dilley noted that Claimant's social and behavioral presentation during the ADOS-2, which is a semi-structured observation instrument used to assess social and communicative behaviors in children and adults who are suspected of having ASD, resulted in a total combined ADOS-2 score of 19, which exceeded the cutoff of 10 for the autism classification. Additionally, Claimant's communication score was 5, and his reciprocal social interaction score was 14. The ADOS-2 results suggested that Claimant exhibited significant symptoms of ASD.

13. To assess Claimant's social perceptual abilities, Dr. Dilley required Claimant to complete a subset from the NEPSY-II, which Dr. Dilley specifically selected to assess Claimant's ability to consider thoughts and feelings of others. Dr. Dilley shared that she used the subtest solely to obtain anecdotal information, as the subtest was normed on children and teenagers up through 16 years old. When comparing Claimant's responses to the responses of 16-year-old individuals, Claimant exhibited an overall total score in the borderline range, comprised of verbal and contextual scores. Overall, Claimant encountered the most difficulty on items that required him to utilize a picture of a social context to identify an image that showed the appropriate effect of one of the people utilized in the picture. He evidenced less difficulty on verbal tasks that assessed his ability to understand another individual's point of view.

14. To assess Claimant's sensory processing, Dr. Dilley required Claimant to complete the Winnie Dunn Adolescent/Adult Sensory Profile, which consists of 60 items used to assess an individual's sensory processing abilities and the effect of sensory processing on functional performance in everyday life. Claimant's responses indicated that he felt "similar to most people" in terms of registering sensory

information in his environment, sensory sensitivity, and sensation avoidance, suggesting Claimant did not experience difficulty noticing, becoming distracted by, or experiencing discomfort related to stimuli, nor did he engage in responses or behaviors in order to avoid environmental stimuli. Overall, Claimant's responses suggested he felt he processed sensory information in a manner similar to that of his peers.

15. To assess Claimant's adaptive functioning, Dr. Dilley administered the VABS-II, which measures an individual's adaptive level or skill in the following domains: Communication, Daily Living Skills, and Socialization. Sister, in collaboration with Mother, completed a paper and pencil version of the VABS-II rating scale at Dr. Dilley's office. Dr. Dilley testified that parents generally collaborate when completing the rating scale, so they can pool their information regarding early childhood development. The responses of the VABS-II indicated Claimant's overall adaptive functioning was low compared to his same age peers. Specifically, Sister's and Mother's responses indicated perceptions of low daily living skills (score: 52, 0.1 percentile); low personal skills (score: 9); low domestic skills (score: 6); low community skills (score: 7); low overall communications skills (score: 36, <0.1 percentile); low receptive communication skills (score: 6); low expressive communication skills (score: 8); moderately low written skills (score 11); low socialization skills (score: 20, <0.1 percentile); low interpersonal relationship skills (score: 1); low coping skills (score: 4); and low play and leisure time skills (score: 3). Sister and Mother rated observations of clinically significant behaviors that impacted Claimant's functioning in his daily life, such as maladaptive behaviors (score: 24); internalizing behaviors (score: 24); and externalizing behaviors (score: 24). Sister and Mother also noted behavioral concerns, such as frequent preoccupations, expression of thoughts that do not make sense, odd or repetitive behaviors, bizarre speech, intentional destruction of property, and lack of

awareness of what is happening around him. Dr. Dilley noted that Sister's and Mother's responses indicated strong concerns regarding Claimant's ability to function independently, and suggested a strong need for assistance and support in each area of his life, including his ability to carry out day-to-day living tasks, his ability to interact with others, and his ability to communicate with others.

16. To assess Claimant's behavioral functioning, Dr. Dilley administered the Achenbach Adult Behavior Checklist, which entailed Sister completing a 126-item checklist to determine the range of internalizing and externalizing behavioral problems exhibited by Claimant. Sister's responses indicated clinical concern regarding Claimant's friendships and perceptions of personal strengths that ranked within the borderline clinical range. Additionally, Sister's responses indicated clinical concern regarding internalizing problems, such as anxiety, depression, and withdrawn behaviors. Sister's responses also indicated clinical concern regarding externalizing problems, such as aggression, and perceptions of rule-breaking and intrusive behaviors that ranked within the borderline clinical range. Further, Sister's responses indicated clinical concern in the areas of thought problems, attention problems, avoidant personality characteristics, sluggish cognitive tempo, and obsessive-compulsive problems. Sister also noted borderline clinical symptoms of ADHD and antisocial personality characteristics.

17. Sister identified several concerns, noting that "when [Claimant] becomes frustrated, he can become very angry and aggressive" and she indicated that "he will fixate on building closets." (Ex. 7, p. 11.) In addition, Sister identified concerns that "once an idea hits him, whether it's rational or irrational, he needs to act on it right away," and also expressed that "he holds grudges and has a photographic memory." She elaborated that Claimant "can't forgive people who hurt him." (*Ibid.*) Sister also

reported that "he can't seem to get it together—life, social skills, job, etc." Sister added that Claimant "fixates on things that make no sense, he always talks about race . . . why he thinks people (minorities) are oppressed. He likes to make class distinctions. He isolates himself from people. His family is the only people he lets into his life. He has no real concept of financial obligations and responsibilities." (*Ibid.*) Sister also noted that Claimant's "mental and emotional state overtake any desire to get ahead in life." (*Ibid.*)

18. Claimant's responses on the BAI and the BDI-II, which assess reported symptoms of anxiety and depression, indicated moderate distress related to an inability to relax and to fearing the worst happening. Claimant also perceived a lot of past failures, felt guilty over things he had done or believed he should have done, felt punished, disliked himself, and slept a lot less than usual. Dr. Dilley also noted that clinical records indicated that Claimant employed a response style that was suggestive of trying to present himself well, thus likely underreporting his symptoms and experiences.

19. To assess Claimant's intellectual ability, Dr. Dilley administered the WAIS-IV, which is an individually administered, comprehensive instrument for assessing current intellectual functioning. Claimant's verbal abilities ranked in the average range and demonstrated average word knowledge and average verbal abstract reasoning. Additionally, Claimant exhibited average ability on a task measuring his general fund of information, and demonstrated average understanding of general principles and social situations. Claimant demonstrated average perceptual reasoning abilities, low average perceptual stimuli abilities, and overall borderline working memory ability. Dr. Dilley noted Claimant's overall intellectual functioning to be in the average range.

20. To assess Claimant's academic achievement, Dr. Dilley administered the WIAT-III, which assesses broad academic achievement in reading, mathematics, and language, and noted Claimant's overall academic achievement was below average. Specifically, his overall reading was below average, in that his basic reading, reading comprehension, and reading fluency were below average. In regard to Claimant's mathematics achievement, his composite score ranked in the average range, in that he scored in the average range in math problem solving and in numerical operations. His overall oral language achievements and written expression were below average.

21. In determining the presence of a learning difference, Dr. Dilley compared Claimant's academic achievements on the WIAT-III to the levels of achievement that would be predicted based on his cognitive abilities per the WAIS-IV. Dr. Dilley discovered a significant discrepancy in the subdomains of sentence composition, oral reading accuracy, and math fluency for addition. The magnitude of these discrepancies was uncommon, occurring less than or equal to one percent (sentence composition, oral reading accuracy) or five percent (math fluency—addition) of the time the two tests were administered. Dr. Dilley noted that Claimant's significant underperformance in sentence composition was consistent with his prior diagnosis of a Specific Learning Disorder with impairment in written expression.

22. When assessing Claimant's auditory and visual attention, Dr. Dilley administered the IVA-2CPT, which is a computerized test of attention and measures an individual's responses to 500 intermixed auditory mixed and visual stimuli spaced 1.5 seconds apart. Claimant did not demonstrate difficulty with sustaining his attention, controlling his impulses, or paying attention to a task. His performance was not indicative of an individual with an attention disorder.

23. When assessing Claimant's visual and perceptual functioning, Dr. Dilley administered Trails A & B, which are gross measures of visual-motor speed, planning, and the ability to shift cognitive set. Claimant demonstrated errors with shifting from letters to numbers, indicative of cognitive set-loss, and with sequencing. Dr. Dilley also administered the VMI-6 to further assess Claimant's visual and motor abilities. Claimant's overall visual-motor abilities were in the below average range, suggesting slight difficulty in visual perception.

24. Dr. Dilley applied ASD criteria set forth in the DSM-5, and found Claimant demonstrated deficits in his ability to sustain reciprocal conversation, as he often engaged in verbose monologues, rather than back-and-forth conversations, and often neglected to inquire about others' interests. He also had difficulty utilizing social context to predict and identify the emotions of others. Dr. Dilley also found that Claimant demonstrated deficits in nonverbal communicative behaviors, in that he used eye contact sporadically and infrequently directed facial expressions to others. Additionally, Dr. Dilley found deficits in Claimant developing, maintaining, and understanding relationships, in that, historically, Claimant had not maintained close relationships with others and had exhibited socially isolative behaviors since early in childhood. Dr. Dilley found Claimant insisted on sameness and demonstrated an inflexible adherence to routines, difficulties with transitions, and rigid thinking patterns, in that he had difficulty transitioning during conversations to speak about topics outside his area of interest, demonstrated difficulty understanding how to integrate various experiences and characteristics into his perspective of others, and demonstrated a black-and-white thought pattern. Dr. Dilley found Claimant had fixated interests that were abnormal in intensity, in that he exhibited a fixed interest in building closets, which has interfered with his attendance to scheduled job interviews, and he has perseverated on several topics of interest during conversations, including

culture, ethics, social rankings, and social experiences. Dr. Dilley noted Claimant's symptoms had been present since childhood, his symptoms had caused clinically significant impairment in social, occupational, or other important areas of current functioning, and his disturbances were not better explained by intellectual disability or global developmental delay.

25. When assessing Claimant's psychological functioning, Dr. Dilley noted Claimant had a history of anxiety, depression, anger, aggression, mood swings, withdrawal, suicidal ideation, self-deprecating comments, and insomnia, and had been diagnosed with Persistent Depressive Disorder, with intermittent major depressive episodes, Generalized Anxiety Disorder, and Social Anxiety Disorder. Dr. Dilley noted that discomfort and anxiety regarding social interactions and relationships was commonly seen in individuals with ASD. At hearing, Dr. Dilley testified that she did not assess Claimant for a personality disorder, because Dr. Valone had already ruled it out.

26. Applying criteria of the DSM-5, Dr. Dilley diagnosed Claimant with ASD; Persistent Depressive Disorder, with intermittent major depressive episodes, with current episode, severe; and Generalized Anxiety Disorder.

27. Dr. Dilley made recommendations to assist Claimant with his social, behavioral, academic, and emotional difficulties. Specifically, Dr. Dilley recommended Claimant to do the following: (1) maintain regular consultation with his psychiatrist and attend all scheduled sessions; (2) resume psychotherapy services with a therapist experienced working with adult individuals with ASD; (3) participate in social skills training; (4) seek out opportunities to engage in pre-established groups, organizations, or activities that align with Claimant's interests; (5) participate in job training and coaching through the Department of Rehabilitation, apply for Medi-Cal services, reapply for Social Security Disability Insurance under an ASD classification, and contact

the Department of Developmental Services to determine services for which he is qualified to receive; (6) submit her written report to his local regional center to apply for eligibility as a regional center client; (7) receive adaptive behavior support services; and (8) consult with Special Education services, should he wish to return to an educational setting, given Claimant's diagnosis of ASD and the corroboration of his prior diagnosis of a learning disorder in written expression.

28. In February 2019, Claimant applied for regional center services, based on Dr. Dilley's diagnosis of ASD. On February 27, 2019, the Service Agency referred Claimant to Nicole Hajjar, MS, CCC-SLP, for a psychosocial assessment.

Criticism of Dr. Dilley's Assessment

29. Jennifer Martinez, Psy.D., licensed clinical neuropsychologist, was contracted by the Service Agency to perform a psychological assessment of Claimant.[2] Dr. Martinez testified at hearing. Dr. Martinez earned her bachelor's degree in psychology from Florida International University in 2010. She earned her master's degree in psychology and her doctorate in clinical psychology, with a concentration in neuropsychology, from Carlos Albizu University in 2013 and 2016, respectively. Since 2018, she has served as a clinical neuropsychologist at Neuro Health, Inc., and at the Service Agency. Prior, Dr. Martinez completed a two-year neuropsychology fellowship at Zucker Hillside Hospital/Long Island Jewish Norwell in New York. Before then, she served as a neuropsychology extern at Miami Jewish Health Systems from September 2014 to June 2015, a psychology extern and neuropsychology extern at Miami Veterans Affairs Hospital from June 2014 to May 2015, and from August 2013 to

[2] Dr. Martinez' assessment report is discussed in great detail in Factual Findings 40 through 62.

September 2014, respectively, a neuropsychology extern at the Neurobehavioral Institute from August 2012 to August 2013, and a psychology extern and practicum student at the Goodman Psychological Center from January 2012 to August 2012. When she served as an extern at Miami Veterans Affair Hospital, she provided counseling to veterans suffering from psychiatric issues. Dr. Martinez has no therapy experience with those diagnosed with ASD, but has experience evaluating them. She is certified to administer the ADOS-2, as well as the SCID.

30. Dr. Martinez' assessment included a review of Dr. Dilley's assessment report. Dr. Martinez noted Claimant administered the second edition of the VABS to assess Claimant's adaptive functioning, as opposed to the most recent edition (i.e., third edition). Consequently, Dr. Martinez gave no weight to Dr. Dilley's findings regarding Claimant's adaptive functioning derived from the VABS-II.

31. Dr. Dilley acknowledged that she used the second edition of the VABS, as opposed to the third edition, which premiered in 2016, one year and three months prior to her administration of the VABS-II. Dr. Dilley used the second edition because Sister and Mother encountered difficulty accessing the third edition online, so Dr. Dilley gave them a paper and pencil version of VABS-II, which is the only paper and pencil version Dr. Dilley had in her office at the time. Dr. Dilley explained that although the VABS-II was not the most current edition, the VABS-II was not obsolete, and she could cite to no criticism of VABS-II.

Psychosocial Assessment by Nicole Hajjar

32. On March 5, 2019, Nicole Hajjar, MS, CCC-SLP, performed a psychosocial assessment on Claimant, who was referred by the Service Agency to "rule out autism spectrum disorder." (Ex. 5, p. 5). Ms. Hajjar prepared a written report, and noted that

when Claimant arrived and greeted the assessment coordinator, he demonstrated fair eye contact. Ms. Hajjar noted Claimant's medical history, in that he had been diagnosed with ASD at Synergy Psychological Inc. (Dr. Dilley), and that he had been diagnosed previously with schizophrenia and bipolar disorder. At the time of the assessment, Claimant was on a daily regimen of Zoloft and Trazodone. Ms. Hajjar noted that Claimant was under the care of physicians, psychologists, and psychiatrists.

33. With respect to Claimant's educational history, Ms. Hajjar noted Claimant completed his high school diploma and completed some college credits at Glendale Community College, but stopped attending college after 18 months when Claimant underwent an appendectomy.

34. With respect to Claimant's current levels of functioning, Ms. Hajjar addressed Claimant's motor skills, communication skills, social/emotional skills, cognitive abilities, independent living/self-care skills, and vocational skills. Ms. Hajjar noted that Claimant had good motor skills. With respect to communication skills, Ms. Hajjar observed Claimant make fair eye contact with familiar and unfamiliar people when communicating, and appropriately initiating conversation with familiar and unfamiliar people depending on his comfort level. Claimant answered questions appropriately during the observation, and was somewhat able to tell a story coherently with relevant details. Claimant's overall communication was characterized by echolalia or repetitive speech patterns, evidenced by his frequent and repeated reminders to himself. Additionally, Claimant inconsistently maintained verbal reciprocity in conversation with communicative partners, and he inconsistently responded with on-topic statements. Ms. Hajjar observed no facial grimacing, hand-flapping, moving in circles, or rocking back and forth when communicating with Claimant.

35. With respect to social/emotional behaviors, Claimant demonstrated openness and affection with his family, but demonstrated difficulty relating to peers. Claimant often interrupted the speaker, but did display appropriate conflict resolution skills by apologizing verbally. During the observation, Claimant demonstrated fair attention and social reciprocity during social interactions with the assessment coordinator. Claimant showed no frustration during transitions or when his needs were not met immediately. Claimant has not required social-skills based services in the past, but Ms. Hajjar noted that some limitations existed in Claimant's social-emotional development, specifically related to social reciprocity.

36. With respect to cognitive abilities, Ms. Hajjar observed that Claimant responded to his name, was able to give his first and last name, name the days of the week, current date, and seasons. He was able to state personal identifying information, including home address and phone number. Ms. Hajjar noted Claimant had good reading comprehension, was able to read a complete story at his age level, and was able to write in complete sentences and paragraphs independently. She also noted Claimant was able to add, subtract, multiply, divide, and tell time independently. Overall, Ms. Hajjar found Claimant's math operations age-appropriate.

37. With respect to independent living and self-care, Ms. Hajjar noted that Claimant was able to feed himself with appropriate utensils, but did not cook food at home. Ms. Hajjar stated Claimant was a good eater, and consumed good quantities. Ms. Hajjar noted Claimant could dress and undress himself, tie his shoes, undo buttons and zippers, brush his teeth, bathe independently, wash his face and hands, and toilet on his own. Claimant also completed chores, such as taking out the trash, assisting his father in the carpet cleaning business, vacuuming, assisting Mother, and making his

bed. Ms. Hajjar noted that Claimant was able to be left alone in the home and that he was able to manage his money.

38. With respect to vocational skills, Ms. Hajjar noted that, at the time of the assessment, Claimant had been working at a company for three months, and that he has previously held employment at various retail stores, restaurants, and bars.

39. Ms. Hajjar recommended the review of Claimant's available medical records, educational records, psychological records, and for the Multidisciplinary Team to review specialists' reports for findings and recommendations.

Psychological Assessment by Dr. Martinez

40. On March 14, 27, and April 17, 2019, Jennifer Martinez, Psy.D., licensed clinical neuropsychologist, performed a neuropsychological assessment of Claimant, to determine current levels of cognitive, adaptive, and social functioning, and to rule out or substantiate a diagnosis of ASD, and prepared a written report.

41. Dr. Martinez conducted a parent interview, reviewed client records from the Service Agency, reviewed Dr. Dilley's neuropsychological assessment report, performed behavioral assessments, and administered the Comprehensive Test of Nonverbal Intelligence, Second Edition (CTONI-2), Test of Premorbid Functioning (TOPF), Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), Childhood Autism Rating Scale, Second Edition (CARS-2ST), Autism Diagnostic Interview, Revised (ADI-R), and the Adaptive Behavior Assessment System, Third Edition (ABAS-3).

42. Dr. Martinez' review of Claimant's medical records showed Claimant had received psychiatric services on several occasions since 1997, and had a longstanding

history of Persistent Depressive Disorder, which began at the age of six; anxiety, which began at the age of 13; and Social Anxiety Disorder, Specific Learning Disorder, Bipolar Disorder, and Schizophrenic Disorder—Bipolar type. Dr. Martinez also noted that Claimant had recently received a diagnosis of ASD, Generalized Anxiety Disorder, and psychosocial and social problems, and was taking Zoloft and Trazodone. Claimant had reported a history of trauma related to bullying when he was in grade school, and reported that he had seen visions and had experienced blank spells when he did not know what was going on around him. Claimant also reported that his soul sometimes leaves his body.

43. In regard to speech and language, Dr. Martinez noted Claimant was able to communicate using detailed and tangential phrases and was able to follow simple directions, as well as answer yes and no questions. She also noted that Claimant's family had reported that conversations with Claimant were one-sided, and he often hyper-focused on preferred topics, such as race, aristocrats, closets, his father, and his childhood. His family also reported that Claimant had poor social reciprocity, often neglected to inquire about other's interests, and had difficulty discussing many of his emotions. Additionally, Claimant had difficulty utilizing social context to predict and identify the emotions of others. Claimant had a history of abnormal eye contact and failed to look others in the eye during conversations.

44. Dr. Martinez noted Claimant "has historically not maintained close relationships with others and has exhibited socially isolative behaviors since early childhood." (Ex. 6, p. 3.) Claimant also preferred to play soccer alone or would engage in parallel play as a young child. At the time of the assessment, Claimant was fixated with building closets in the stairwell of his father's work building. Behaviorally, Claimant demonstrated a rigid pattern of thinking, and had difficulty transitioning. Dr.

Martinez observed Claimant display poor eye contact during the assessment sessions, and noted that conversational speech was one-sided, he showed limited interest in her, his thought process was tangential and perseverative, and his thought content evidenced delusional and paranoid content.

45. In order to assess Claimant's cognitive skills, Dr. Martinez administered the TOPF, which predicts intellectual and memory performance and is composed of a list of 70 words that have atypical grapheme to phoneme translations, and CTONI-2, which is an unbiased measure of nonverbal reasoning abilities in individuals for whom most other mental ability tests are either inappropriate or biased. The results of the TOPF, which enables clinicians to estimate an individual's level of cognitive and memory functioning before the onset of injury or illness, showed that Claimant's premorbid functioning to be in the low average range. The CTONI-2 showed Claimant to be in the average range on the Pictorial Scale Composite, on the Geometric Scale Composite, and on the Full-Scale Composite.

46. To determine whether Claimant had ASD and to assess his social-emotional and personal functioning, Dr. Martinez administered the CARS-2ST, which is a clinical rating scale to rate items indicative of ASD, the ADI-R, which is a standardized, semi-structured clinical interview for caregivers of children and adults to help diagnose whether an individual has ASD, and the MMPI-2, which is a clinical assessment tool to help diagnose mental health disorders. The results of CARS-2ST placed Claimant in the Minimal-to-No Symptoms of Autism Spectrum Disorder range. The results of the ADI-R showed Claimant's scores were not consistent with a classification of ASD. On the MMPI-2, which consisted of 567 true-false questions, Claimant responded in a highly defensive manner and attempted to present himself in a favorable light. As such, Dr. Martinez concluded the resulting MMPI-2 clinical and

content scale profiles could be an underestimate of Claimant's present symptoms and psychological adjustment.

47. To assess Claimant's adaptive functioning, Dr. Martinez administered the ABAS-3, which is a rating scale designed to assess functioning in 11 related adaptive skill areas: communication, community use, functional academics, school/home living, health and safety, leisure, self-care, self-direction, social, work, and motor. Claimant's overall level of adaptive behavior fell in the Extremely Low range.

48. Dr. Martinez concluded that a discrepancy existed between Claimant's current adaptive abilities when compared to his peers, signaling a poor developmental trajectory; however, Dr. Martinez stated it was "important to rule out any apathetic-related psychological factors that may be impeding his adaptive functioning given his history of depression and psychosis." (Ex. 6, p. 9.) She further stated the following:

> Social withdrawal, communication impairment, and poor eye contact is commonly seen in individuals diagnosed with schizoaffective disorder. Individuals with schizoaffective disorder also have difficulty with cognitive flexibility and perseveration, which can cause difficulty with transitioning and/or changing topics while conversing. Thought blocking, concrete thinking, and paranoia are common in psychosis, which can impede an individual's ability to pick up on social cues and/or avoid social interactions. In addition, flat affect is common in both schizoaffective disorder and autism, which can also make it difficult to interact socially.

(*Ibid*.)

49. Dr. Martinez concluded the following:

> In [Claimant's] case, his hyper-focused topics appear to be more delusional in nature and are likely related to his psychosis and an underlying ***Paranoid Personality Disorder.*** Specifically, [Claimant's] persistent mental disorder (schizoaffective disorder), was preceded by a preexisting paranoid personality disorder. Individuals with paranoid personality disorder may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own. [Claimant's] paranoia may have begun during his childhood years following traumatic bullying, which resulted in difficulty maintaining close relationships. Although [Claimant] has a longstanding history of difficulties in nonverbal communication, he does **not** meet the DSM-V criteria for [ASD] . . . Therefore, a diagnosis of [ASD] is unsubstantiated and ruled out.

(Ex. 6, p. 10.) (Emphasis in original.)

50. In applying DSM-5 criteria for ASD, Dr. Martinez concluded Claimant did not meet the criterion requiring deficits in social-emotional reciprocity, in that Claimant's hyper-focused topics appeared to be more delusional in nature and likely related to his schizoaffective diagnosis and his underlying Paranoid Personality

Disorder. Dr. Martinez explained that individuals with Paranoid Personality Disorder may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own.

51. Dr. Martinez concluded Claimant met the ASD criterion requiring deficits in nonverbal communicative behaviors used for social interaction, in that Claimant had a history of abnormal eye contact, failed to look others in the eye during conversations, and had difficulty understanding social and contextual cues in conversations.

52. Dr. Martinez concluded Claimant did not meet the ASD criterion requiring deficits in developing, maintaining, and understanding relationships, as Claimant reported that he had a lot of friends and was very sociable. Dr. Martinez stated that Claimant's "difficulties in social relationships are likely related to his paranoia and mistrust of others as opposed to an organic deficit." (Ex. 6, p. 11.)

53. Dr. Martinez concluded Claimant did not meet the ASD criterion of stereotyped or repetitive motor movements, use of objects, or speech, as Claimant denied any repetitive or stereotyped motor movements. Claimant did meet the ASD criterion for insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior, as records indicated Claimant demonstrated a rigid pattern of thinking. Claimant did not meet the ASD criterion of demonstrating highly restricted, fixated interests that are abnormal in intensity or focus, in that although Claimant had demonstrated fixation with building closets, such behavior could be related to goal-directed behavior often seen in individuals suffering from Bipolar Disorder. Claimant also did not meet the ASD criterion of hyper- or

hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment, in that Claimant denied any difficulties with sensory processing.

54. Dr. Martinez concluded Claimant met the ASD criterion that Claimant's symptoms were present in his early developmental period. Dr. Martinez also concluded Claimant met the criterion that Claimant's symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning, as Claimant's symptoms impact his ability to engage in age-appropriate activities with others. Finally, Dr. Martinez concluded that Claimant's disturbances were not better explained by intellectual disability or global developmental delay.

55. Because Claimant did not meet all of the criteria related to persistent deficits in social communication and social interaction across multiple contexts, and did not meet two or more criteria related to restricted, repetitive patterns of behavior, interests, or activities, Dr. Martinez concluded Claimant did not meet the DSM-5 criteria for ASD.

56. Dr. Martinez diagnosed Claimant with Paranoid Personality Disorder (Premorbid) and Antisocial Personality Disorder—Deferred. Dr. Martinez recommended the following: (1) Claimant continue to manage his mood and psychosis through medication; (2) Claimant to attend individual and/or group therapy; (3) Claimant's family to receive psychoeducation; and (4) Claimant to engage in healthy living practices in order to increase optimal functioning.

Criticism of Dr. Martinez' Assessment

57. Dr. Dilley reviewed Dr. Martinez' assessment and disagreed with Dr. Martinez' conclusion that Claimant did not have a developmental disability, but instead suffered from Paranoid Personality Disorder and Antisocial Personality

Disorder. Dr. Dilley acknowledged Claimant had paranoid thinking, but explained that his paranoid thinking was due to ASD, as he had a strong history of perseverative thinking. Because Claimant did not receive appropriate services for neurodevelopmental issues as a child, such as Applied Behavioral Analysis (ABA), Dr. Dilley believed Claimant had not learned the coping strategies to handle his anxiety and to navigate social interactions and the social facets of engagement. Dr. Dilley further explained that because of Claimant's extreme level of perseveration, he experiences great shame and distress when he fails to appear neurotypical. Claimant believes he was subjected to witchcraft in utero, which the family has reinforced, which is why he believes he has all of the trouble he has.

58. Dr. Dilley pointed out that the results of Dr. Martinez' ABAS assessment showed that Claimant's scaled score in each of the adaptive skill areas, specifically, communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, and social, was 1, described as "extremely low," and Claimant also scored in the extremely low range in the conceptual, social, and practical adaptive domains. (Ex. F, p. 14.) Dr. Dilley believes these symptoms were present when Claimant was a child, which is consistent with Dr. Martinez' finding that Claimant met the criterion that Claimant's symptoms were present in his early developmental period.

59. Dr. Dilley also took issue with Dr. Martinez' failure to administer the ADOS. Although Dr. Martinez administered the ADIR to assess whether Claimant had ASD, Dr. Dilley noted the ADOS is the "gold standard" of ASD testing. Dr. Dilley explained that the ADOS is a better measure because the clinician must have specialized training to administer the test, and it requires direct interaction between the clinician and the subject, as opposed to reviewing rating scales. Dr. Dilley also explained that the ADIR is often used in conjunction with, not instead of, the ADOS. Dr.

Martinez testified that she did not administer the ADOS, because a false-positive rate exists with individuals with psychiatric conditions.

60. Dr. Dilley noted that Dr. Martinez did not assign Claimant with a diagnosis of Schizoaffective Disorder, despite concluding that Schizoaffective Disorder preceded Paranoid Personality Disorder. Additionally, Dr. Martinez opined that Claimant's Schizoaffective diagnosis was, in part, related to the delusional nature in which Claimant "hyper-focused" on topics, as opposed to finding deficits in Claimant's social-emotional reciprocity under the DSM-5 criteria for ASD. (Ex. 6, p. 10.) Dr. Martinez testified that she did not assess Claimant for Schizoaffective Disorder, because he had a previous diagnosis of Schizoaffective Disorder, and believed the diagnosis "could be appropriate." Dr. Dilley testified that if Dr. Martinez believed that Claimant suffered from Schizophrenia or Schizoaffective Disorder, her report should have included the diagnosis. Dr. Dilley also noted that Dr. Martinez did not include a diagnosis of Bipolar Disorder in her report even though Dr. Martinez had opined that, with respect to the DSM-5 ASD criteria, Claimant's highly restricted and fixated interests, namely building closets, "may be related to goal-directed behavior often seen in bipolar disorder." (Ex. 6, p. 11.)

61. Dr. Dilley disagreed with Dr. Martinez' conclusion that Claimant did not meet the DSM-5 ASD criterion of suffering deficits in developing, maintaining, and understanding relationships. Dr. Martinez based her conclusion on Claimant's self-report that he had "lots of friends"; however, Dr. Dilley explained that Claimant is high-functioning enough to want to fit in with social norms, so he can talk about neurotypical activities, but, in reality, is unable to execute those activities. Additionally, both Dr. Dilley and Dr. Martinez acknowledged in their respective reports that Claimant tried to present himself in a favorable light. In reality, according to Dr. Dilley,

Claimant exhibited great difficulty in maintaining close relationships, referenced friendships from several years prior, but talked about them as though they were current, and exhibited socially isolative behaviors since early childhood. Moreover, irrespective of Dr. Martinez' finding that Claimant did not meet the DSM-5 ASD criterion of suffering deficits in developing, maintaining, and understanding relationships, Dr. Martinez' own words contradict this finding: "[Claimant] has historically not maintained close relationships with others and has exhibited socially isolative behaviors since early childhood." (Ex. 6, p. 3.)

62. Dr. Martinez acknowledged at hearing that a high percentage of individuals with ASD may have comorbid mental health disorders.

Multidisciplinary Eligibility Team

63. In June 2019, the Service Agency's Multidisciplinary Eligibility Team met and reviewed the neuropsychological assessment performed by Dr. Dilley, the psychosocial assessment performed by Ms. Hajjar, and the psychological assessment performed by Dr. Martinez. The Multidisciplinary Team concluded Claimant did not present with a developmental disability and thus did not qualify for regional center services. The Multidisciplinary Eligibility Team relied on the results of the completed assessments, and determined they were consistent with the diagnoses of Paranoid Personality Disorder (Premorbid) and Antisocial Personality Disorder—Deferred.

64. The Service Agency sent Claimant a letter on July 1, 2019 setting forth the Multidisciplinary Eligibility Team's determination, and referred Claimant to Dr. Martinez' assessment report for further explanation and clarification. The Multidisciplinary Eligibility Team recommended Claimant to contact the Department of Rehabilitation for vocational assistance, to participate in appropriate social

opportunities, to continue regular medical and dental care, and to continue psychiatric care and medication treatment.

65. On August 5, 2019, Sister, on Claimant's behalf, filed a Fair Hearing Request.

Sister's Testimony

66. Sister, who is an optometrist, testified at hearing. Sister is 48-years-old, 12 years older than Claimant, and witnessed his early years growing up. Sister moved out of the house when she was 19-years-old to attend college, and returned home every weekend, holiday, and school break. In 2000, Sister pursued her doctorate in Puerto Rico and returned home in 2004. Claimant currently lives at Sister's home, as well as in Mother's home, spending time at both homes during the course of the week.

67. Sister testified Claimant does not follow directions well and is obsessed and repetitive about building things, particularly closets. When Claimant was a child, he repeatedly and consistently built skyscrapers out of paper, and covered the entire living room with his skyscrapers. Claimant also has significant self-care issues. For instance, Claimant does not seem to understand he needs to shower on a regular basis, and is not motivated to shower without prompting, even when he has developed substantial body odor. Claimant also needs constant reminders to brush his teeth, close the door when he defecates, flush the toilet after he defecates, and wash his hands after using the bathroom, and engaged in similar behaviors long before he turned 18-years-old.

68. Sister also testified that Claimant eloped as a child, and still elopes today. Specifically, Claimant elopes "when he gets the impulse to go," and it is very difficult to change his mind from leaving, even when it is dangerous for him to do so. For

example, he will get an impulse to leave the house in the middle of the night to go to church, even though it is closed, or to go to their father's office building.

69. Sister explained that Claimant has communication challenges, in that he does not seem to understand body language or social cues. For example, when Sister becomes frustrated with Claimant and expresses that frustration through body language, facial expressions, and tone of voice, Claimant's reaction is flat, in that he has a blank expression on his face. Claimant had these communication challenges in his childhood.

70. Claimant relies on Sister and Mother to address his financial affairs; he cannot do so on his own. Claimant does not understand negative bank balances and how to correct them. He also makes regular repetitive statements, particularly at night, like "Am I going to be okay?" or "Why did God make me like this?" When he was a child, Claimant would make repetitive statements on a regular basis, such as "meow" and "Sponge Bob Square Pants."

71. Claimant has had "a handful" of jobs over the years, but has been unable to maintain them.

72. Sister does not believe Claimant has mental illnesses. Claimant does not display signs of psychosis, such as hearing voices, but Sister does agree that Claimant suffers depressed moods, has trouble concentrating, experiences anxiety, and only trusts his family. Sister believes that ASD is at the root of Claimant's behaviors and mental state. Claimant was never tested for ASD before the age of 18.

Mother's Testimony

73. Mother testified at hearing and discussed Claimant's early development. Specifically, Mother shared that Claimant had very limited speech as a child and did not speak in complete sentences until he was nine-years-old. Claimant urinated in his pants until he was 11 or 12-years-old. He could not wipe himself after defecating, and she still has to remind Claimant to wipe himself or he will smell bad. Mother also consistently reminds Claimant to take showers, which she has had to do his entire life. Additionally, Mother has to remind Claimant to brush his teeth, which she has always had to do. If Claimant is not prompted to maintain his personal and dental hygiene, he will not do it. Claimant was 16 or 17-years-old when he learned to tie his shoes, and 15 or 16-years-old when he learned to button his own shirt and pants. Claimant eats the same things every day, does not like to deviate from those foods, and did the same thing as a child.

74. Claimant has lived in Mother's home for most of his life, and she served as his primary caretaker during his childhood. Mother has taken Claimant to many professionals over the years to secure help for him, including to Cedars-Sinai Medical Center, UCLA Hospital, General Hospital, and many other places. None of those experts diagnosed Claimant with ASD as they never tested Claimant for the disorder. Mother observed Claimant suffer depression and anxiety, but disagrees Claimant is "insane" or has schizophrenia. Rather, Mother believes Claimant has ASD.

Credibility Findings[3]

75. Dr. Dilley and Dr. Martinez were credible expert witnesses, as they were thorough, knowledgeable, comprehensive, and had a good command of all the reports

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3 The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code, § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." *(Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman &*

reviewed in connection with their respective assessments. However, Dr. Dilley's wealth of experience exceeded that of Dr. Martinez, in that Dr. Dilley has been a licensed clinical psychologist for 13 years, while Dr. Martinez has been licensed for only four. During that time, Dr. Dilley has developed an impressive expertise in the area of ASD and other neurological disorders, evidenced not only by her specialized training in the area, but by her presentations in the areas of ASD assessment, ASD diagnosis, and ASD treatment. Additionally, Dr. Dilley's assessment of Claimant appeared more comprehensive than Dr. Martinez', in that Dr. Dilley administered the "gold standard" of tests to assess for ASD, namely the ADOS, while Dr. Martinez assumed such a test would produce a false-positive given what she deemed as the presence of psychosis. However, Dr. Martinez, although citing the presence of Schizoaffective Disorder as justification, in part, for her finding that Claimant did not meet DSM-5 ASD criteria, neither tested nor diagnosed Claimant with Schizoaffective Disorder. Additionally, Dr. Martinez opined that, with respect to the DSM-5 ASD criteria, Claimant's highly restricted and fixated interests, namely building closets, were related to goal-directed behavior seen in Bipolar Disorder, but she did not diagnose Claimant with Bipolar Disorder. (Ex. 6, p. 11.)

76. While Dr. Martinez criticized Dr. Dilley's assessment for her failure to use the most recent edition of the VABS when assessing Claimant's adaptive skills

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Clark Corp. v. Fallon (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

functioning, neither Dr. Martinez nor the Service Agency established that the VABS-II used by Dr. Dilley was obsolete, invalid, or elicited inaccurate results.

77. In light of the above, Dr. Dilley's testimony and report are credited over that of Dr. Martinez, and Dr. Dilley's opinions are afforded great weight.

78. Sister and Mother were credible witnesses, as they testified in a clear, concise, and straightforward manner, and their respective testimony corroborated the other's. As such, Sister's and Mother's testimony are afforded significant weight.

LEGAL CONCLUSIONS

1. An administrative hearing to determine the rights and obligations of the parties, if any, is available under the Lanterman Act to appeal a contrary service agency decision. (Welf. & Inst. Code, §§ 4700-4716.) Claimant requested a hearing to contest Service Agency's denial of Claimant's eligibility for services under the Lanterman Act and therefore jurisdiction for this appeal was established. (Factual Findings 1-3.)

2. Generally, when an applicant seeks to establish eligibility for government benefits or services, the burden of proof is on him to prove by a preponderance of the evidence that she meets the criteria for eligibility. (*Lindsay v. San Diego County Retirement Bd.* (1964) 231 Cal.App.2d 156, 161; Evid. Code, §§ 115, 500.) "Preponderance of the evidence means evidence that has more convincing force than that opposed to it. [Citations] . . . [T]he sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is the quality of the evidence. The quantity of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 324-325.)

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as:

> [A] disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. . . . [T]his 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.

4. To prove the existence of a qualifying developmental disability within the meaning of Welfare and Institutions Code section 4512, Claimant must show that he has a "substantial disability." Pursuant to Welfare and Institutions Code section 4512, subdivision (*l*)(1):

> "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:
>
> (A) Self-care.
>
> (B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

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

(a) "Substantial disability" means:

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

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

6. California Code of Regulations, title 17, section 54001, subdivision (b), provides, in pertinent part, that the "assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines," and the "group shall include as a minimum a program coordinator, a physician, and a psychologist."

7. In addition to proving that he suffers from a "substantial disability," Claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: intellectual disability, epilepsy, autism, and cerebral palsy. The fifth and last category of eligibility is listed as "[d]isabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability." (Welf. & Inst. Code, § 4512.)

8. Here, the evidence established that Claimant has significant functional limitations in at least three areas of major life activity, as described in Legal Conclusion 5. Specifically, Claimant has limitations in his receptive and expressive language, as evidenced by the results of the VABS-II, in that Claimant scored in the low range in the area of communication, including receptive and expressive communication. As additional support, Dr. Martinez' administration of the ABAS-3 showed Claimant scored in the extremely low range across the communication skill domain area. Claimant also demonstrated limitations in learning, evidenced by Claimant's Specific

Learning Disability discussed by Dr. Dilley, particularly regarding his significant underperformance in academic achievement when compared to his cognitive abilities. Moreover, Claimant is challenged by self-care and self-direction, evidenced by the credible testimony of Sister and Mother, who must instruct Claimant in many areas of his daily life, including daily hygiene tasks, and by the results of the VABS-II and the ARAS-3 showing Claimant scored in the low and in the extremely low ranges in these areas, respectively. Finally, the evidence shows that Claimant's capacity for independent living and economic self-sufficiency is limited, given his inability to maintain a job, his inability to manage his finances, and his complete reliance on his family to provide for his daily needs and to prompt him to execute daily personal hygiene tasks and appropriate toileting protocol.

9. Claimant also demonstrated that he has a "substantial disability" (as defined in the Lanterman Act and Title 17 of the regulations) resulting from one of the five qualifying conditions specified in Welfare and Institutions Code section 4512, namely Autism, Intellectual Disability, Cerebral Palsy, Epilepsy, or a condition closely related to Intellectual Disability or requiring treatment similar to that required for individuals with Intellectual Disability. Specifically, Claimant proffered credible evidence demonstrating that he has ASD, as set forth in Dr. Dilley's comprehensive assessment report, based on Claimant's performance on the tests administered by Dr. Dilley, including the ADOS-2, as well as Dr. Dilley's application of the test results to the DSM-5 ASD criteria, which Claimant met. (Factual Findings 7 through 31.)

10. Claimant proffered no evidence demonstrating he suffers from Cerebral Palsy, Epilepsy, or an Intellectual Disability. The assessment of whether Claimant suffers from a fifth category condition requires consideration of both prongs of potential fifth category eligibility, i.e., whether Claimant suffers from a disabling condition found to

be closely related to Intellectual Disability or whether Claimant requires treatment similar to that required for individuals with Intellectual Disability. (Welf. & Inst. Code § 4512, subd. (a).)

11. 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]. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well." *(Id.*, at p. 1129.) It is therefore important to track factors required for a diagnosis of Intellectual Disability when considering fifth category eligibility.

12. The presence of adaptive deficits alone is not sufficient to establish Intellectual Disability or fifth category eligibility. (*Samantha C. v. State Dept. of Developmental Services* (2010) 185 Cal.App.4th 1462, 1486 [Intellectual Disability "includes both a cognitive element and an adaptive functioning element" and to "interpret fifth category eligibility as including only an adaptive functioning element" misconstrues section 4512, subdivision (a)].) Claimant has not established that he suffers from the kind of general intellectual impairment found in persons with Intellectual Disabilities, nor is there sufficient evidence to establish that Claimant's adaptive deficits stem from cognitive deficits.

13. Determining whether a Claimant's condition "requires treatment similar to that required" for persons with Intellectual Disability is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people, including those who do not suffer from Intellectual Disability, or any developmental disability, could benefit from the types of services offered by

regional centers (e.g., counseling, vocational training, living skills training, or supervision). The criterion therefore is not whether someone would benefit from the provision of services, but whether that person's condition requires treatment similar to that required for persons with Intellectual Disability, which has a narrower meaning under the Lanterman Act than services. (*Ronald F. v. State Dept. of Developmental Services* (*Ronald F.*), (2017) 8 Cal.App.5th 84, 98.)

14. Claimant presented no evidence establishing he meets the second prong of the fifth category.

15. Based on the foregoing, Claimant established by a preponderance of the evidence that he is eligible for regional center services under the Lanterman Act under the qualifying category of ASD. As such, Claimant's appeal shall be granted. (Factual Findings 1 through 78; Legal Conclusions 1-15.)

ORDER

Claimant's appeal is granted. Service Agency's determination that Claimant is not eligible for services under the Lanterman Act is overturned.

DATE:

CARLA L. GARRETT
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.