BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: JANELLE J., Claimant, vs. NORTH LOS ANGELES COUNTY REGIONAL CENTER, Service Agency.	OAH No. 2012100687

DECISION

Administrative Law Judge Michael A. Scarlett, Office of Administrative Hearings, State of California, heard this matter on February 11, 2013, in Lancaster, California. Rhonda Campbell, Contract Officer, represented North Los Angeles County Regional Center (Service Agency or NLACRC). Jacqueline E. (Mother) was present and represented Janelle J. (Claimant).[1]

Oral and documentary evidence was received, and argument was heard. The record was closed and the matter was submitted for decision on February 11, 2013.

ISSUE

Does Claimant have a developmental disability entitling her to eligibility for regional

[1] Claimant's last initials are used in this Decision, in lieu of her surname, in order to protect her privacy.

center services?

FACTUAL FINDINGS

1. Claimant is a five-year, eight month old girl who currently resides with her mother, age 31, and five siblings, one sister, 14 years old, and four brothers, 9, 10, and 11 years old, and 23 months. Mother seeks regional center eligibility for Claimant based upon mental retardation and/or autism. Claimant and the 9 and 10 year-old brothers have the same father, who is currently incarcerated serving a five-year sentence for a domestic violence conviction for conduct against Mother. Mother and the four younger children lived in a shelter for a period of time because of this father's domestic violence. Claimant's older two siblings have the same father, and until recently were living with a maternal grandmother. The 23 month old sibling also has a different father. Mother had no information about any of the fathers' family or medical history. Claimant is currently attending kindergarten at El Dorado Elementary School in the Lancaster School District. The school district had not conducted an initial Individualized Education Program (IEP) for Claimant by the date of this hearing.

2. On August 13, 2012, Service Agency determined that Claimant was not eligible for regional center services. Service Agency based its determination upon a social assessment dated May 7, 2012, prepared by Viktoria Penchuk, M.A. (Penchuk), an Intake Vendor for the Service Agency; a June 5, 2012, medical summary prepared by Carlo De Antonio, M.D., FAAP; a July 12, 2012, psychological evaluation prepared by Ann Walker, Ph.D.; and an August 31, 2011, Child & Family Guidance Center Client Care Coordination Plan. Mother provided no independent assessments or evaluations in support of Claimant's application for regional center services. The Service Agency denied services to Claimant and issued a Notice of Proposed Action (NOPA) on August 13, 2012. On October 11, 2012, Claimant submitted a request for fair hearing. Although the fair hearing request was submitted outside the 30-day time period to file an appeal of the Service Agency's

denial of eligibility, Service Agency did not object that the fair hearing request was untimely. On November 7, 2012, Service Agency proceeded to an informal meeting with Claimant, and deferred an "informal decision" on Claimant's appeal pending a school observation by a regional center psychologist. On January 31, 2013, after a school observation was conducted by Sandi J. Fisher, Ph.D., Service Agency again advised Claimant that she was not eligible for regional center services and that if she was not in agreement with the ineligibility determination, Claimant should proceed to fair hearing. All jurisdictional requirements have been satisfied to proceed to hearing.

3. Claimant received mental health services through Child and Family Guidance Center (CFGC) in 2011. On August 31, 2011, a Client Care Coordination Plan was developed for Claimant by CFGC. She received therapy to increase anger control and to decrease physical aggression. Claimant's aggressive behaviors and "attitude" were attributed to her exposure to violence in the home as a result of her father's domestic violence against Mother.

4. On May 7, 2012, Service Agency conducted a social assessment of Claimant in conjunction with her application for regional center services. Claimant's Mother and two of her brothers, ages 9 and 10, were present during the social assessment. Mother was the main source of information for the social assessment. Claimant was born full term without complication and Mother received prenatal care. Claimant started walking and spoke her first words at 18 months and began speaking in sentences at age two. Claimant is fully ambulatory and has no motor limitations or restrictions. During the assessment Claimant initiated communications with her siblings, Mother, and the assessor. She was talkative and engaging throughout the assessment. Although Claimant displayed some disruptive behavior, it was not considered aggressive. Claimant's self-help skills as described by Mother were deemed age-appropriate. Mother reported Claimant was "fully potty-trained" but during the school observation by Dr. Fisher in January 2013, Claimant was

observed to have wet her pants on two occasions.

5. Claimant demonstrated "good social skills" during the social assessment. She responded to her name when called, made appropriate eye contact, and initiated and sustained conversations. Claimant had "poor impulse control" as evidence by her difficulty in waiting her turn to answer questions and she constantly tried to engage her brothers to play during the assessment, although both were not responsive to her overtures. Mother reported that Claimant plays with other children and toys in an appropriate manner, but that she could sometimes be disruptive and throw manageable temper tantrums. During the assessment she was observed engaging in imaginary play with hand puppets. Mother reported that Claimant is able to recognize social cues appropriately and share enjoyment and interests with others. The assessor did not observe, and Mother did not report, any restricted repetitive stereotyped patterns of behavior or body mannerisms by Claimant. She reacted normally to transitions and changes in routine. Mother reported that Claimant "babbles a lot," but the assessor did not observe any signs of "echolalia or babbling." Mother also reported that Claimant exhibited no self-injurious behaviors, she would not wander away, she had common safety awareness, and that she did not require constant supervision in familiar settings.

6. On June 5, 2012, Dr. Carlo De Antonio, M.D., reviewed the available medical records pertaining to Claimant. Dr. De Antonio's medical summary concluded that there is no basis for a diagnosis of cerebral palsy or epilepsy. Claimant offered no medical evidence to the contrary to support a diagnosis of cerebral palsy or epilepsy.

7. On July 12, 2012, Dr. Walker performed a psychological evaluation on Claimant for purposes of an eligibility determination for regional center services. Dr. Walker administered the Wechsler Preschool and Primary Scales of Intelligence-3rd Edition (WPPSI-III), the Autism Diagnostic Observational Schedule, Module 2 (ADOS, Module 2), the Autism Diagnostic Interview-Revised (ADI-R), the Gilliam Autism Rating Scale-2nd

Edition (GARS-2), and the Vineland Adaptive Behavior Scales-2nd Edition (Vineland II). He also conducted a clinical interview and reviewed Dr. De Antonio's medical summary and the May 7, 2012 social assessment performed by Penchuk.

8. Dr. Walker noted that Claimant did not have separation issues when taken by the examiner to a separate test room for the psychological evaluation. Per the observations of the examiner, Claimant was easily engaged in the tasks of the evaluation, had a lot of energy and was talkative. She showed a brief attention span of one to two minutes, but when distracted, she was easily redirected to test materials. Claimant gave good effort and seemed eager to demonstrate her skills during the evaluation. Mother completed the GARS-2 independently and was interviewed to complete the Vineland II and the ADI-R. Mother was noted to be an honest and accurate informant by the examiner. The testing was completed in one hour and 25 minutes.

9. On the WPPSI-III, Claimant's verbal cognitive intellectual abilities tested in the normal or average range overall (Verbal IQ score of 95) and her nonverbal cognitive intellectual abilities were in the borderline range (Nonverbal IQ score of 79). A Full Scale IQ was not indicated due to the 16-point difference in the verbal and nonverbal scores. Claimant's Subtest Scaled Scores were as follows: Information 10 (average range); Vocabulary 10 (average range); Word Reasoning 10 (average range); Block Design 7 (low average range); Matrix Reasoning 6 (low average range); Picture Concepts 7 (low average range); and Coding 8 (average range). Dr. Walker noted weaknesses in Claimant's visual sequential reasoning.

10. Administration of the Vineland II rendered an Adaptive Behavior Composite score of 70 (borderline or low range) with the following specific standard domain scores:

(a) Communication Skills: Claimant tested in the borderline range (domain standard score of 72). She could pronounce more than 100 words, but did not know any letters and could not recognize her name in print.

(b) Sensorimotor Skills: Claimant's motor skills were in the borderline range (domain standard score of 72). Mother reported that she could throw and catch a ball, ride a tricycle, and alternate feet up and down a stair case. Claimant was observed completing two-piece puzzles, holding a pencil correctly in her fingertips and building a block bridge.

(c) Social Adaptive Skills: Claimant's social adaptive skills were in the borderline range. Her self-help or daily living domain standard score was 77, and her socialization skills domain standard score was 75. It was noted that Claimant is able to eat with a fork and spoon and drink from a cup with spillage. She is not completely toilet trained and has accidents frequently. Claimant helps with some chores, talks on the telephone and can turn on the television. She engages in cooperative interactive imitative and imaginary play with others, and sometimes takes turns, and will share toys if asked.

11. The ADOS, Module 2 and the ADI-R indicated that Claimant's scores were below the autism-spectrum and autism cut-offs indicating that Claimant did not exhibit behaviors that would support a diagnosis of the autism-spectrum or autistic disorder. The ADOS, Module 2 yielded a total communication and reciprocal social interaction score of "2", with the autism cut-off being 12, and the autism-spectrum cut-off being 7. The examiner observed that Claimant spoke a lot and engaged in spontaneous conversations. She did not show stereotypic use of words, pointed with visually directed referencing, and showed a variety of gestures. Claimant was observed to sustain good eye contact and showed a variety of facial expressions, which were directed to others. She shared enjoyment when interacting with the examiner. She showed the examiner objects of interest and initiated joint attention using eye contact to reference an object and looked to the examiner and back to the object with coordinated gestures and words and eye contact

to initiate joint attention. It was noted that claimant's social response was appropriate in that she formed a "cooperative, friendly and relaxed rapport" with the examiner.

12. The ADI-R yielded a score of "3" for abnormalities in reciprocal social interaction, with the autism cut-off being 10, and scores of "0" for abnormalities in communication and restricted and stereotyped patterns of interests, with the autism cut-off being 8 and 3 respectively. Mother reported that Claimant uses eye contact to engage in social interaction but typically avoids eye contact with her Mother when she has been naughty or misbehaves. Mother also reported that Claimant is developing appropriate peer relationships. She is able to share interest and enjoyment and show emotional reciprocity with Mother noting that Claimant notices how mother feels and tries to comfort mother with hugs if mother is upset or hurt. Claimant shows no significant delays in expressive or receptive language skills. She was observed engaging in reciprocal conversations during the evaluation and Mother reported that she engages in reciprocal conversations with her sister. Claimant plays with Barbie dolls and braids their hair. Mother reported no unusual adherence to routine, repetitive motor mannerisms, or sensory sensitivity.

13. On the GARS-2, which Mother completed independently, Claimant's Autism Index score was 70 or two percent, including subscale standard scores of "3" for stereotypic behavior, "7" for communication skills, and "6" for social interaction skills. Mother expressed concerns about Claimant avoiding eye contact, repeating words and phrases, using gestures instead of words to express her needs, not initiating conversations with adults, and having frequent temper tantrums. However, these behaviors were not consistent with the observations reported by the examiner during the psychological evaluation.

14. Dr. Walker concluded that Claimant did not meet the criteria for mental retardation based upon Claimant's WPPSI-III and the Vineland II tests scores. Claimant

performed in the normal range for verbal intelligence, the borderline line range for nonverbal intelligence, and the borderline range for social skills, gross and fine motor skills, self-help and communication skills. Based upon the ADOS, Module 2, the ADI-R, and the GARS-2, Dr. Walker concluded that Claimant did not meet any of the criteria for a diagnosis of autism under the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, 4th Edition, Text Revision (DSM-IV-TR).

15. Dr. Walker diagnosed Claimant with Enuresis (noting her toileting accidents for urine), Attention Deficit-Hyperactivity Disorder (ADHD), combined type, Oppositional Defiant Disorder (ODD), and Learning Disorder NOS (noting a weakness in visual sequential reasoning). She recommended that Claimant be referred to a pediatrician for treatment of the ADHD. Dr. Walker also recommended that Claimant and Mother continue therapy, specifically advising that Mother receive parenting skills training and behavioral therapy to address Claimant's Enuresis and ODD, and that Claimant receive therapy to improve her ability to express anger appropriately. Finally, Dr. Walker stated that claimant should be referred for an appropriate school placement.

LEGAL CONCLUSIONS

1. Claimant did not establish that she suffers from a developmental disability entitling her to regional center services. (Factual Findings 1 through 15.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a Claimant seeks to establish his or her eligibility for services, the burden is on the appealing Claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met her burden of proof in this case.

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),[2] defines "developmental disability" as:

> a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4. To prove the existence of a developmental disability within the meaning of section 4512, an individual must have a "substantial disability." Section 4512, subdivision (l), defines "substantial disability" as the existence of significant functional limitations in three or more of the following areas of major life activity: (1) self-care, receptive and expressive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, and (7) economic self-sufficiency. California Code of Regulations, title 17, section 54001, subdivision (a), provides that:

> (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] All further references are to the Welfare and Institutions Code unless otherwise indicated.

(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.

5. Claimant must show that her "substantial disability" fits into one of the five categories of eligibility in section 4512. These categories are mental retardation, epilepsy, autism and cerebral palsy, and a fifth category of eligibility described as having "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (§ 4512, subd. (a); Cal. Code. Regs., tit. 17, § 54000.) Under the Lanterman Act, "developmental disability" excludes conditions that are *solely* physical in nature. (§ 4512; Cal. Code. Regs., tit. 17, § 54000.) Section 54000, subdivision (c), excludes conditions that are *solely* psychiatric disorders, learning disabilities, or physical in nature.

AUTISTIC DISORDER

6. Dr. Walker's July 12, 2012, psychological evaluation and the May 7, 2012, social assessment established that Claimant does not have an Autistic Disorder. The DSM-IV-TR states that "the essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a

markedly restricted repertoire of activity and interests." The DSM-IV-TR describes the diagnostic criteria for autism to include the following:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(b) failure to develop peer relationships appropriate to developmental level;

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);

(d) lack of social or emotional reciprocity;

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime);

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;

(c) stereotyped and repetitive use of language or idiosyncratic language;

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals;

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);

(d) persistent preoccupation with parts of objects;

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

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

(DSM-IV-TR at pp. 70-71, and 75.)

7. Claimant's May 7, 2012, social assessment indicated that she was very talkative and engaging throughout the assessment. She initiated and sustained conversations and demonstrated good social skills. Claimant made good eye contact with the assessor, responded to her name when called, and was constantly trying to engage her siblings to play during the assessment. Dr. Walker administered the ADOS, Module 2 and the ADI-R tests during the July 12, 2012, psychological evaluation. Claimant's scores on these two tests were below the Autism Disorder and Autism-Spectrum cut-offs. Consistent with observations during her social assessment, Dr. Walker indicated that Claimant was easily engaged when performing the testing during the evaluation, showed good eye contact, displayed a lot of energy and was very talkative. She spoke a lot and engaged in spontaneous and reciprocal conversations with the examiner. Mother reported that Claimant often engages in conversations with her older sister and she has established

appropriate peer relationships. Claimant did not exhibit significant delays in expressive or receptive language during the social assessment or psychological evaluation. Dr. Walker concluded that Claimant had not met any of the criteria required for a diagnosis of autism under the DSM-IV-TR. Claimant presented insufficient evidence to the contrary. Accordingly, Claimant failed to establish that she is entitled to regional center eligibility based upon a diagnosis of Autism.

MENTAL RETARDATION

8. The DSM-IV-TR defines Mental Retardation as follows:

> The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.
>
> General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for

Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. Adaptive functioning refers to how effectively individuals cope with common life demands and how well

> they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR at pp. 39 - 42.)

9. Regarding Mild Mental Retardation (I.Q. level of 50-55 to approximately 70), the DSM-IV-TR states:

> [Persons with Mild Mental Retardation] typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. By their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(Id. at pp. 42 - 43.)

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

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

(Id. at p. 48.)

11. Claimant's WPPSI-III verbal and nonverbal cognitive functioning scores indicated that she was performing in the average and borderline ranges respectively. There was a 16-point difference in the tests scores: verbal 95 and nonverbal 79. However, neither the verbal or nonverbal cognitive functioning scores fell within the range of mild mental retardation (IQ level 50-70). The DSM-IV-TR states that when there are such discrepancies across verbal and nonverbal scores, averaging to obtain a full-scale IQ score can be misleading. The DSM-VI-TR suggests that a profile of strengths and weaknesses, rather than a full-scale IQ, will more accurately reflect a person's learning abilities. Dr. Walker declined to give a full-scale IQ score for Claimant because of the 16-point difference in the tests scores. However, she noted that Claimant exhibited strengths in the areas of word knowledge and general information (indicative of her average subtest scaled

scores in Information, Vocabulary, Word Reasoning and Coding) and weakness in her visual sequential reasoning (reflecting her low average subtest scale scores in Block Design, Matrix Reasoning and Picture Concepts). Dr. Walker attributed the weakness in the visual sequential reasoning to the presence of a learning disability, rather than a cognitive deficiency associated with mental retardation. Claimant's WPPSI-III scores did not establish that she has significant subaverage intellectual functioning given Claimant's strengths in vocabulary, word reasoning, information, and coding.

12. The DSM-IV-TR also provides that to establish mental retardation, there must be significant limitations or deficits in adaptive functioning in at least two of the skill areas specified in Paragraph 9 above. "Adaptive functioning" refers to whether a person can effectively cope with common life demands and can meet the standards of personal independence expected of someone their age, sociocultural background, and community setting. The Vineland II was used to measure Claimant's adaptive functioning levels. Claimant scored in the borderline range across all domains of adaptive functioning including communication, motor, daily living and socialization skills. Claimant's Adaptive Behavior Composite score of "70" was also in the borderline range. However, the evidence showed that Claimant did not have significant deficits in any of the skill areas applicable to a child of her age. Claimant displayed good communication skills during her social assessment and psychological evaluation as she was observed being talkative and engaging. She displays age-appropriate social interaction, although she has a tendency to be disruptive and impatient on occasion, and may throw manageable temper tantrums. But this behavior was not deemed to be aggressive and is attributable to her diagnosis of ADHD and ODD. Claimant's self-help skills are age-appropriate. She is capable of feeding herself, even though she is messy at times, she helps with minor chores like putting away her toys and making her bed, but she is not able to dress herself. Claimant also is not completely toilet trained and has frequent wetting accidents both during the day and at

night. This is consistent with the diagnosis of Enuresis. Claimant has age-appropriate safety awareness, does not wander off, and does not require constant supervision when in familiar settings. Finally, Claimant is fully ambulatory and has no major medical or health concerns. Although the Vineland II indicated borderline adaptive functioning based upon Mother's interview information, the evidence did not establish the presence of significant limitations or deficits in Claimant's adaptive functioning.

13. Accordingly, given Claimant's present level of intellectual functioning, arguably low average to average or normal range, and her adaptive functioning skills being at worst in the borderline range, there is insufficient evidence to conclude that Claimant is eligible for regional center services based upon a diagnosis of mental retardation.

FIFTH CATEGORY

14. Under the fifth category, the developmental disability must be "closely related" or "similar" to mental retardation, or "require treatment" similar to that required for mentally retarded individuals. As stated above, there must be a significant degree of cognitive and adaptive deficits to establish mental retardation. Thus, to be closely related or similar to mental retardation, there must also be significant cognitive and adaptive deficits for an individual to be deemed to have a disability like that of a person with mental retardation. Although this does not require strict application of all of the cognitive and adaptive criteria utilized in establishing mental retardation, there must be evidence of significant deficiencies in cognitive and adaptive functioning. That is not the case here. Claimant's test scores indicated that she was scoring generally in the low average to average range for cognitive functioning and in the borderline range for adaptive functioning. Eligibility under the fifth category requires a showing that the cognitive and adaptive functioning has an effect or impact on Claimant that renders her like a person with mental retardation. There is insufficient evidence to conclude that Claimant's cognitive and adaptive skill deficiencies render her disability similar to a person with

mental retardation. Claimant's deficiencies in cognitive and adaptive functioning properly supported a diagnosis of ADHD, ODD and Learning Disability. Claimant presented no evidence to contradict these diagnoses.

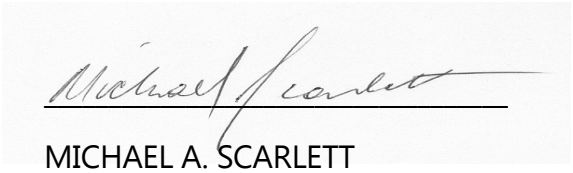
15. Claimant's social assessment and psychological evaluation did not make recommendations that would typically be considered "treatment similar" to persons with mental retardation. Dr. Walker recommended that Claimant be referred to a pediatrician for treatment for ADHD, that Mother receive parent skills training, and Claimant behavior therapy, to address the Enuresis and ODD, and an appropriate school placement was recommended to address Claimant's Learning Disability. Given Claimant's good medical condition and history, there were no treatment recommendations made relative to health concerns. The recommended treatments sought to address ADHD, ODD, and Learning Disability, and do not constitute treatments similar to that which would be required for a person with mental retardation. Claimant presented no evidence to the contrary, and therefore, a fifth category basis for eligibility was not established.

16. Claimant has not established that she qualifies for regional center services based upon a diagnosis of mental retardation, fifth category eligibility, or an Autistic Disorder, by reason of Factual Findings 1 through 14, and Legal Conclusions 1 through 15. Claimant has been diagnosed with ADHD, ODD, Enuresis, and a Learning Disability. These are not qualifying developmental disabilities upon which Lanterman Act eligibility may be based. Consequently, the Service Agency's denial of Claimant's eligibility must be upheld.

ORDER

The Service Agency's determination that Claimant Janelle J. is not eligible for regional center services is upheld. Claimant's appeal is denied.

DATED: May 10, 2013



MICHAEL A. SCARLETT

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.