BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, v. VALLEY MOUNTAIN REGIONAL CENTER, Service Agency.	OAH No. 2014020189

DECISION

A fair hearing was held on January 14 and 23, and April 2, 2015, before Karen J. Brandt, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, in Stockton, California.

Anthony Hill, Assistant Director of Case Management, represented Valley Mountain Regional Center (VMRC).

Claimant's mother and stepmother represented claimant.

Evidence was received, the record was closed, and the matter was submitted for decision on April 2, 2015.

ISSUES

Does claimant qualify for VMRC services because he is an individual with an intellectual disability, or because he has a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an

intellectual disability (generally referred to as the "fifth category")?[1] Or is he excluded from receiving VMRC services because his impaired intellectual functioning is solely the result of his psychiatric disorders and/or treatment given to him for such disorders?

FACTUAL FINDINGS

1. Claimant was born in 1998. He is currently 16 years old. Claimant's mother and stepmother sought services for claimant from VMRC under the Lanterman Act's developmental disability categories of intellectual disability[2] and the fifth category. VMRC denied their request, asserting that claimant was excluded from receiving regional center services under California Code of Regulations, title 17, section 54000, subdivision (c)(1), because his impaired intellectual functioning was solely the result of his psychiatric disorders.

2. At the hearing, Barbara Ann Johnson, Psy.D., VMRC's Clinical Psychologist,

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[1] When claimant's parents requested VMRC services, there was a question about whether claimant might be eligible under the developmental disability category of autism. At hearing, claimant's representatives confirmed that they were not seeking VMRC services for claimant under that category, because Kaiser Permanente's Autism Spectrum Disorder Center determined in April 2014 that claimant was not an individual with an Autism Spectrum Disorder.

[2] The language used to describe intellectual disability has changed over time. When claimant was first evaluated in 2005, the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR was in effect. It included the diagnosis of "mental retardation." In March 2013, the DSM-5 was issued. It changed the terminology from "mental retardation" to "intellectual disability." Effective January 1, 2014, the Lanterman Act was amended to change the term "mental retardation" to "intellectual disability."

reviewed the numerous evaluations and assessments that have been conducted over the past 10 years regarding claimant's intellectual functioning and psychiatric conditions. Those evaluations and assessments are summarized below, followed by Dr. Johnson's testimony regarding them.

EVALUATIONS AND ASSESSMENTS OF CLAIMANT

3. Psychoeducational Assessment – February and March 2005. The first evaluation offered at hearing was a Psychoeducational Assessment conducted by the Tracy Unified School District (Tracy) on February 15 and 23, and March 10, 12, and 14, 2005, when claimant was six years seven months old and a student in the first grade. The assessment was conducted at the request of claimant's parents. An RSP teacher[3] and a School Psychologist conducted the assessment. The assessment noted that claimant had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and was taking medication at school to treat his ADHD symptoms.

4. In conducting the assessment, the assessors reviewed records, observed claimant in his classroom, interviewed claimant and his parents, consulted with his classroom teacher, and administered the following tests: Wechsler Intelligence Scale for Children, Third Editions (WISC-3), Woodcock-Johnson Cognitive Battery 3 (WJ-3) – Verbal Comprehension subtest, Children's Memory Scale (CMS), Young Children's Achievement Test (YCAT), Woodcock-Johnson Psychoeducational Battery, Third Edition (WJ-3) – Oral Language cluster, Wide Range Achievement Test (WRAT-3), Process Assessment of the Learner (PAL) – pseudoword decoding subtest, Comprehensive Test of Phonological Processing (CTOPP), the Phonological Awareness Test (PAT), Achenbach Child Behavior Checklist, Teacher Rating Form (TRF), and Achenbach Child Behavior Checklist, Parent Rating Form (CBCL).

[3] "RSP" stands for resource specialist program.

5. Claimant's testing was conducted over five separate days "due to extreme difficulty sustaining his focus to task." According to the examiner, claimant

> … required frequent redirection to task. He often wanted to handle the test material rather than letting this examiner present materials to him. His activity level was very high, and he was very easily distracted and very impulsive, even in a 1:1 setting. Attitude during testing was generally good. Effort was generally good. In this examiner's view, assessment tools were appropriate for this student and current assessment results are generally a reliable and valid indicator of his skills at this time. It is felt that results do represent a mild underestimate of his skills and abilities, related to his extreme difficulty in sustaining attention to task.

6. On the WISC-3, claimant attained a Full Scale IQ of 84. The assessment noted that claimant's IQ score was "prorated" because "Coding was not included in the results." The assessors analyzed claimant's WISC-3 IQ scores as follows:

> [Claimant's] Verbal Scale IQ of 85 is in the low average range and indicates fair verbal cognition. His prorated Performance Scale IQ of 86 is the low average range and indicates fair nonverbal cognition. Full Scale IQ of 84 is in the low average range and indicates fair overall cognition. Verbal comprehension is comparable to perceptual organization, indicating comparable verbal and nonverbal skills.

7. The assessors summed up their findings, in relevant part, as follows:

> [Claimant] was referred for psychoeducational assessment due to concerns in behavior, attention, academic delays, language and fine and gross motor skills. Results indicate fair cognitive skills, poor reading, fair to average math, fair to average written language achievement, fair to poor phonological awareness, fair phonological memory, very poor rapid naming, average visual memory for letters and words, fair to poor visual memory for objects, very poor verbal memory, very poor behavior and very poor attention. A significant discrepancy does not appear to exist between ability and achievement. Processing deficits are indicated in the areas of verbal memory and attention. Results indicate that he does not qualify for Special Education Services as a student with a specific learning disability. Results indicate that he qualifies for Special Education Services as a student with Other Health Impairment (OHI), as chronic, severe, documented attention problems adversely affect educational performance, as evidenced by off-task behavior despite good effort and difficulty completing tasks in class.

8. Psychoeducational Assessment – February 2008. Tracy conducted another Psychological Assessment of claimant on February 25, 28, and 29, 2008, when claimant was nine years six months old and in the fourth grade. The assessment was conducted as part of claimant's triennial evaluation, when he was receiving educational support in a special day classroom and pull-out speech and language services based upon his eligibility for Special Education services under the category of OHI. The assessors were

an SDC teacher[4] and a School Psychologist.

9. In conducting their assessment, the assessors reviewed records, observed claimant's behavior in his classroom and during the assessment, interviewed claimant, and administered the following tests: Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV), Woodcock Johnson Test of Achievement, Third Edition (WJ-III ACH), CMS, CTOPP, Developmental Test of Visual-Motor Integration, Fifth Edition (VMI-V), and Behavior Assessment System for Children-Second Edition (BASC-II).

10. On the WISC-IV, claimant received a Verbal Comprehension Composite score of 71, a Perceptual Reasoning Composite score of 82, a Working Memory Composite score of 68, and a Processing Speed composite score of 68, for a Full Scale IQ score of 67. The assessors described claimant's scores on the subtests as follows:

> … [claimant's] Verbal Comprehension of 71 is in the borderline range and indicates poor verbal comprehension. His attained score for the Perceptual Reasoning Composite of 82 is in the low average range and indicates fair perceptual reasoning, which encompasses nonverbal concept formation, visual perception and organization and simultaneous processing. Further, his Working Memory Composite of 68 is in the extremely low average range and indicates very poor memory. His Processing Speed Composite of 68 is in the extremely low average range and suggests very poor processing speed.

[4] "SDC" stands for Special Day Class.

> Upon analyzing the index scores, there appears to be three significant differences. [Claimant] scored significantly higher for tasks that measure perceptual reasoning skills in comparison to tasks that measure verbal comprehension skills, working memory skills and processing speed. Therefore, it appears that [claimant's] perceptual reasoning skills are more developed. Further, [claimant] has appeared to demonstrate a significant strength on a task that measures abstract and categorical reasoning skills and no significant weakness.

11. The assessors summarized the results of their assessment, in relevant part, as follows:

> … [Claimant] appeared eager to participate in the assessment and the results appear to be a valid indicator of his cognitive functioning abilities. Results indicate borderline verbal abilities and low average perceptual reasoning abilities with his cognitive skills in the extremely low average to borderline range. Additionally results indicate very low reading abilities, low average math abilities and very low written language achievement. Results also indicate poor phonological awareness, fair phonological memory, very poor rapid naming skills, low average memory and impaired to borderline verbal memory, as well as fair visual-motor integration skills. His teacher reported scores in the clinically significant range in terms of his hyperactivity, conduct

problems, externalizing problems, anxiety, depression and behavioral symptoms index.

12. The assessors concluded that claimant did not qualify for Special Education services as a student with a specific learning disability, finding that a "significant discrepancy does not appear to exist between ability and achievement." But they found that he continued to qualify for Special Education services as a student with an OHI, finding that:

> His teacher reported scores in the at-risk range for attention problems and scores in the clinically significant range for the hyperactivity subscale as assessed by the BASC-2. Further, during the classroom and assessment observations, [claimant] appeared to have some difficulty staying on-task and needed to be redirected and prompted back to the task at hand. Based on the assessment results and information, it would appear that [claimant] would continue to qualify as a student with other health impairment at this time.

13. Psychoeducational Assessment – December 2010. Tracy conducted a Psychological Assessment of claimant on December 10 and 15, 2010, when claimant was 12 years four months old and in the seventh grade. The assessment was conducted when claimant was being considered for expulsion. It was to be used to meet triennial evaluation requirements and to provide data for claimant's upcoming Manifestation Determination IEP.[5] Claimant was alleged to have: (1) followed and threatened two girls; (2) thrown rocks at one of the girls, pulled her to the ground by her hair, and hit her

[5] "IEP" stands for Individualized Education Program.

when she was on the ground; and (3) hit another student with a pipe when he asked claimant to stop. The assessment was conducted by an SDC teacher and a School Psychologist. The assessment noted that claimant had 27 discipline referrals between the 2005-6 to 2008-9 school years. The assessment described eight behavioral referrals/suspensions that claimant had during the 2009-10 school year, including the referral underlying the expulsion recommendation.

14. In conducting the assessment, the assessors reviewed claimant's records, observed his classroom behavior, consulted with his classroom teacher, interviewed claimant, and reviewed the reports of claimant's parents, psychiatrist, and school staff. The assessors administered the following tests: Wechsler Intelligence Scale for Children, Fourth Edition (WISC-4) – partial, Kaufman Brief Intelligence Test, Second Edition (KBIT-2), Cognitive Assessment System (CAS), Planned Codes subtest and Attention subtests, Children's Memory Scale (CMS), Immediate Story Memory subtest, Woodcock-Johnson Achievement Test, Third Edition (WJ-3), CTOPP, and BASC-2.

15. Because of scheduling issues, the testing had to be completed in one session. The assessment described claimant's behavior during testing, in relevant part, as follows:

> [Claimant] entered testing easily. Attitude during testing was good. Effort was generally good. Attention span was inconsistent, and he became distracted and fidgety as testing progressed despite several breaks. He presented as extremely active and uninhibited, and frequently went off on tangents. He responded to redirection. He tended to comment during the test, either by laughing when hearing the nonsense words on the CTOPP, noting that something was easy or difficult, etc. He sometimes switched strategies,

> especially on timed tests, for example chunking numbers partway through digit memory, which hampered his performance. He presented as happy, friendly and outgoing, as well as extremely unfocused. He seemed to enjoy the testing and 1:1 attention, especially earlier in testing. He complained of having a migraine headache during WISC-4 testing, and testing was discontinued shortly thereafter.

The assessors opined that the results of the testing were "considered to be an accurate reflection of [claimant's] current skills but do not reflect his full potential due to his extreme lack of focus."

16. The assessors described the partial testing results that claimant received on the WISC-4 as follows:

> WISC-4 Verbal Comprehension subtest results indicate poor associational reasoning. Perceptual Reasoning Composite of 79 is in the borderline range and indicates poor to fair nonverbal reasoning. Digit Span results indicates very poor auditory short-term memory.

On the KBIT-2, claimant received a Verbal IQ score of 83, a Nonverbal IQ score of 71, for an IQ Composite score of 73. The assessors concluded that claimant's results on the KBIT-2 indicated "fair verbal reasoning and poor nonverbal reasoning." They concluded that the:

> … [p]attern of results generally indicates low average to borderline reasoning skills (80+/-10). Very poor working memory and processing speed have consistently been

> indicated. It is possible that his learning potential is better developed than is indicated by test results due to his short attention span.

17. The assessors noted that claimant had been initially diagnosed with ADHD, and had been more recently diagnosed with Bipolar Disorder, Not Otherwise Specified, and Oppositional Defiant Disorder. The assessors also noted that, when claimant was diagnosed with Bipolar Disorder, Not Otherwise Specified, stimulant medication that he had been taking was stopped, and Abilify, a mood stabilizer, was introduced.

18. The assessors found that claimant's "primary learning challenges include his short attention span, high activity level and impulsivity." They summarized their conclusions as follows:

> Results indicate fair to poor cognitive skills, very poor reading, poor math, and very poor written language achievement. Processing assessment indicates poor to fair phonological awareness, fair phonological memory, very poor rapid naming, very poor story memory, and very poor attention. Behavior is indicated to be very poor. He continues to qualify as a student with other health impairment (OHI), as he has severe, longstanding attention deficit. This deficit results in inconsistent work completion and impulsive behavior, such as calling out and sometimes getting out of his seat.
>
> A significant discrepancy appears to exist between ability and achievement in the areas of reading and written language associated with processing deficits in the areas of

> attention and auditory processing. The deficit results in some difficulty sounding out short and long words, slow reading rate, and resulting difficulty understanding what he reads. Direct links to attention deficit is noted in the previous paragraph. Results indicate that he qualifies for Special Education Services as a student with a specific learning disability.

19. Psychoeducational Assessment – April 15, 2013. Lincoln Unified School District (Lincoln) conducted a Psychological Assessment of claimant on April 15, 2013, when claimant was 14 years old and in the eighth grade at Children's Home of Stockton. The assessment was conducted by a School Psychologist. She noted that, at the Tracy Manifestation Determination IEP in 2010, it was determined that a "more restrictive placement would better serve [claimant's] academic, behavioral and emotional needs." Consequently, Tracy placed claimant at the Children's Home of Stockton. Claimant was transferred to Lincoln when his father and stepmother moved to the area covered by that school district. Lincoln decided to continue claimant's placement at the Children's Home of Stockton.

20. The assessment also noted that a review of claimant's records indicated that "behavioral concerns have included hitting, throwing objects at others and peers, kicking and verbal defiance." His Children's Home of Stockton teacher and school administrator reported that claimant's "behavior has improved overall this school year and the most concerning behaviors include verbal defiance, an inability to emotionally deal with peer conflicts and a lack of motivation related to school based activities." The School Psychologist noted, however, that claimant had recently been involved in an "episode of property destruction on the school grounds which involved kicking out a window." It was reported that claimant's "most consistent behavioral trigger" appeared

to be "failed peer interactions including peer conflict." Claimant was retained in the eighth grade by the Children's Home of Stockton.

21. In conducting her assessment, the School Psychologist observed claimant, reviewed his records, interviewed his parents, teacher and school administrator, and administered the following tests: WISC-IV, Test for Auditory Perceptual Skills (TAPS-3), Beery Developmental Test of Visual-Motor Integration (VMI), Emotional and Behavior Problem Scale-2 (EBPS-2), Reynolds' Adolescent Depression Scale (RADS), BASC-2, Differential Test of Conduct and Emotional Problems (DT/CEP), and Woodcock-Johnson Test of Achievement Third Edition.

22. The School Psychologist described claimant's behavior during the assessment, in relevant part, as follows:

> [Claimant] approached the testing environment with no apparent anxiety. He was friendly with the examiner, however, he quickly began asking questions regarding how long the testing would take, stating that he had a headache, that he was "tired" and that he was "bored". Testing was completed over several sessions due to his tendency toward disengagement from assessment activities, stating that he was tired, yawning and task refusal. … Rapport was established at each session and this examiner stopped each session once he began engaging in disengagement. Results appear to be a valid estimate of [claimant's] day-to-day functioning as his behavior, mood and affect appeared consistent over several assessment periods.

The School Psychologist found that claimant had "significant difficulties with attending skills." He "often asked for repetition of directions and if auditory prompts could be repeated." He "appeared distracted by sounds and visuals in his environment." His affect was "lethargic." The School Psychologist had to "utilize consistent verbal prompting to encourage him to remain on tasks." The School Psychologist concluded that:

> While the assessment results discussed in this report are considered an accurate reflection of [claimant's] ability to demonstrate various skill levels day to day, it is this examiner's opinion that his scores reflect an underestimate of his full potential due to his extreme lack of focus, negative affect, attention span and tendency toward a lethargic personality. A review of records suggests that his performance on various measures of intellect has declined over the years possibly related to further mental health symptom manifestation.

23. On the WISC-IV, claimant received a Verbal Compression Composite score of 65, a Perceptual Reasoning Composite score of 73, a Working Memory score of 56, and a Processing Speed score of 50. The School Psychologist stated that claimant's performance on the WISC-IV

> … fell into the delayed range and at the 0.1st percentile. The 8-point difference between verbal and performance skills is not significant. A subtest scatter analysis indicates that [claimant] appears to have relative strengths in tasks requiring visual perceptual reasoning skills. Relative

> weaknesses appear to be in tasks requiring processing speed.

24. The School Psychologist summarized her findings with regard to claimant's intellectual functioning, in relevant part, as follows:

> [Claimant's] achieved performance on assessment measures appears to indicate borderline to delayed cognitive abilities. As discussed in the testing observation section of this report [claimant's] scores on current measures of intellectual skill may represent a somewhat underestimate of his true intellectual potential due to his behavioral profile and his lack of engagement demonstrated during assessment. However, it is this examiner's conclusion the results obtained ARE a valid estimate of how [he is] able to perform day to day at this time due to his behavioral and mental health symptom profile. (Capitalization in original.)

25. In her assessment, the School Psychologist concluded that claimant continued to qualify for Special Education services in the Other Health Impaired category given his ADHD and Bipolar Disorder diagnoses. She also concluded that he qualified under the category of Emotional Disturbance, finding that:

> *[Claimant's] academic performance may be affected by overall decreased intellectual functioning, however, his emotional/behavioral profile makes gaining an accurate estimate of his intellectual functioning difficult. It appears*

that learning challenges are related to more than intellectual, sensory or health conditions alone. (Italics in original.)

The School Psychologist also found that:

> [Claimant's] assessment does not indicate significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifest during the developmental period which adversely affect educational performance.

26. Psychiatric Admission – October 2013. On October 4, 2013, when claimant was 15 years old, he was admitted to Sierra Vista Hospital under Welfare and Institutions Code section 5150.[6] Claimant was alleged to have tried to light his mother's dog on fire,

[6] Welfare and Institutions Code section 5150, in relevant part, provides:

> When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention….

punched walls, and threatened his mother. Claimant was discharged from Sierra Vista Hospital on October 23, 2013. The discharge summary noted that claimant was on psychotropic medications, including Abilify, Strattera, Clonidine, and Lamotrigine.

The discharge summary noted further that claimant's "mother wanted him to be taken off the medication but she agreed to taper some of the medication." It also noted that, whenever claimant became agitated, he requested Haldol, which "he reported makes him feel calmer and quieter." The discharge diagnoses set forth in the discharge summary include on Axis I "Mood Disorder Not Otherwise Specified. Attention Deficit Hyperactivity Disorder, Inattentive Type. Intellectual Disability." On Axis II, the discharge summary stated "Deferred." There is no indication in the discharge summary how it was determined that claimant had an Intellectual Disability. The only reference in the discharge summary to claimant's IQ stated, "[Claimant's] mother felt that he has a lower IQ and he was due for an IEP which would enable her to put him in the state facility on a long term basis for safety because she feels unsafe at home with him around with all the behaviors he has done and threatening them." There is no other information in the discharge summary to indicate how a diagnosis of Intellectual Disability was made or on what information it was based.

27. On October 24, 2013, claimant was placed in Edgewood Center's Hospital Diversion Program for "stabilization." During his 14-day stay at Edgewood, claimant received medication assessment and intervention, individual therapy, family therapy, supportive milieu interventions, and psychotherapeutic group sessions. According to the Treatment Summary and Discharge Plan, during his stay, claimant "displayed persistent irritability, with occasional verbal and very rare physical outbursts to staff…" Claimant was treated with Celexa for depression and anxiety symptoms. He was also started on Benadryl for his sleep problems. These two medications were added to the four listed in Finding 26 above.

Upon discharge from Edgewood, claimant's diagnoses on Axis I were "Mood Disorder NOS," "ADHD NOS," and "R/O Pervasive Developmental Disorder NOS."[7] On Axis II, his diagnosis was "R/O: Mild Mental Retardation." There is no information in the Treatment Summary and Discharge Plan to indicate how this rule-out diagnosis was made or on what information it was based.

28. Juvenile Hall Incarceration – December 2013. On December 13, 2013, claimant was booked into Juvenile Hall after he assaulted his mother and vandalized her home. Claimant's mother reported that claimant "choked" her during an argument, pushed a television onto the floor, and knocked a coffee pot to the floor, causing it to break. Claimant's mother also reported that, earlier in the year, claimant strangled his father's dog and her cat. She reported further that, in 2012, claimant tried to suffocate a child.

29. Forensic Psychiatry Report – Competency to Stand Trial Evaluation – December 2013. On December 23 and 26, 2013, John M. Yarbrough, M.D., a Child, Adolescent and Adult Forensic Psychiatrist, conducted an evaluation to determine if claimant was competent to stand trial. As set forth in his December 30, 2013 evaluation report, Dr. Yarbrough found that claimant met the DSM 5 criteria for Conduct Disorder, childhood-onset type, with limited prosocial emotions, severe, Attention Deficit Hyperactivity Disorder, combined presentation, and Autism Spectrum Disorder. Dr. Yarbrough also found that claimant was competent to stand trial for assault, battery and vandalism.

30. Kaiser Records – 2013 and 2014. Medical records from Kaiser Permanente for 2013 and 2014 were admitted into the record. These records include various diagnoses that claimant was given, the psychiatric treatment he obtained, and the

[7] "R/O" stands for Rule Out. "NOS" stands for Not Otherwise Specified.

psychotropic medications he received. The diagnoses included in these records include, "ADHD, Inattentive," "Personal Condition of Behavioral Problem," "Intellectual Disability, Moderate," and "Disruptive Behavior Disorder." There is no information set forth in these records to explain how the diagnosis of "Intellectual Disability" was made. There is no indication in these records that Kaiser ever conducted any testing of claimant to determine his intellectual functioning.

31. Psychological Assessment – December 2013. VMRC referred claimant for a psychological assessment by Robert L. Mattesich, a Licensed Education Psychologist, to assist VMRC in determining whether claimant was eligible for services under the Lanterman Act. Mr. Mattesich conducted his assessment on December 30, 2013, when claimant was 15 years four months old. The assessment was conducted at the San Joaquin County Juvenile Detention Center, where claimant was then being detained.

32. Mr. Mattesich administered the WISC-IV, and the Vineland Adaptive Behavior Scales: Second Edition. On the WISC-IV, claimant attained a Verbal Comprehension Score of 71, a Perceptual Reasoning Score of 75, a Working Memory Score of 71, and a Processing Speed score of 73, for a Full Scale IQ score of 67. With regard to this score, Mr. Mattesich stated, "While this score indicated presence of significant impairment in cognitive functioning it was viewed by this examiner as possibly under-estimating [claimant's] potential."

33. On the Vineland Adaptive Behavior Scales: Second Edition, claimant attained an Adaptive Behavior Composite score of 74, suggesting the "presence of below average adaptive behavior skills."

34. Mr. Mattesich described claimant's behavior during testing, in relevant part, as follows:

> [Claimant] readily accompanied this examiner. After building rapport this examiner attempted to administer the math

> portion of the WRAT-IV. [Claimant] became angry and uncooperative. This examiner terminated the administration of the achievement tests. This examiner presented the block design subtest from the WISC-IV. [Claimant's] mood state changed from being angry/annoyed to smiling and stating "I like to do these." He remained cooperative until the conclusion of the testing. [Claimant's] vocabulary was less than average, but he exhibited an adequate functional use of language. Specific deficits in speech articulation were not evident, and this examiner had no difficulty understanding his spoken language. This examiner asked [claimant] how an elbow and a knee are similar and he responded "they are both joints." While he did smile appropriately and make eye contact he appeared to have significant emotional issues. He was very guarded and, as noted, his mood would swing dramatically. It was this examiner's impression that his emotional issues likely contributed to his depressed score on the standardized test. His performance on standardized tests was also possibly affected by the influence of the numerous medications he takes.

35. Mr. Mattesich concluded that, "As noted results from current testing were viewed as possibly under-estimating [claimant's] intellectual potential due to the influences of his emotional impairment and various prescribed medications." Mr. Mattesich's report does not include any opinions about whether claimant may qualify for services from VMRC under any of the categories of developmental disabilities included in the Lanterman Act. Mr. Mattesich stated that claimant would be "most

successful when he is in a structured setting where distractions are minimized and both auditory and visual cues are utilized," and that claimant "would likely benefit from a supportive counseling component."

36. County Behavioral Health Services Letter – March 2014. On March 1, 2014, Thomas C. Maples, Ph.D., LMFT, at San Joaquin County Behavioral Health Services, sent a letter to claimant's mother to summarize his "diagnostic impressions, treatment regimen, and progress [claimant] has made toward his treatment goals while being retained at San Joaquin County Juvenile Justice Center." With regard to claimant's intellectual functioning, Dr. Maples stated:

> [Claimant's] primary diagnosis is now viewed Mental Retardation, Mild Severity. [Claimant] is reported to have conflicting IQ testing results, ranging between 53 and 78, with the most recent evaluation conducted by VMRC showing an overall IQ of 67. [Claimant] shows a high degree of impulsivity, shows problems with paying attention to detail, has difficulties organizing tasks, and is easily distracted. He shows difficulties reading simple sentences when tested in a rule chart at intake, and showed difficulties reading three letter words. [Claimant] shows impairments in functional adaptation in his ability for self-direction, his ability to attain functional academic skills, learn work related skills, and his capacity to control his emotional state in a manner that is not a threat to others. As a stand alone diagnosis, [claimant's] Mild Mental Retardation may further effect [*sic*] his capacity to effectively engage in age appropriate social relationships, give and receive emotional

> reciprocity, engage effectively in multiple areas of interest, and learn age appropriate social expectations due [to] the learning handicaps associated with this disorder.

37. In his letter, Dr. Maples stated that claimant's mother "reported overall IQ testing results ranging from 53 to 78 on the WISC IV…" Except for this statement and the reference to the recent VMRC evaluation, there is no other information set forth in Dr. Maples' letter to indicate the testing he relied upon in reaching his impressions as to claimant's intellectual functioning.

38. Kaiser Genetics – March 2014. Billur Moghaddam, M.D., in the Genetics Department at Kaiser Permanente, wrote a letter dated March 16, 2014, which stated, "[Complainant] is a 15 year old young man who is being evaluated and followed [b]y our genetics department and he is undergoing genetic studies. [¶] At present, it is my impression that he has Global developmental delay, cognitive disability and some features of autism spectrum disorder." There is nothing further in Dr. Moghaddam's letter to explain how she reached her impression.

39. Treatment Center Admission – May 2014. On May 2, 2014, claimant was admitted to Victor Treatment Center, a level 14 therapeutic group home for severely emotionally disturbed youth. At this center, claimant receives mental health rehabilitation services and medication support.

40. Psychological Evaluation – August and September 2014. On August 14 and 26, and September 4, 2014, Anna Westin, Ph.D., Postdoctoral Psychology Fellow, and Blake D. Carmichael, Ph.D., Psychologist II Supervisor, at the CAARE Diagnostic and Treatment Center at U.C. Davis Children's Hospital, conducted a psychological evaluation of claimant when he was 16 years old and in the ninth grade at Victor Treatment Center. The evaluation was requested by claimant's San Joaquin County social worker to "clarify [claimant's] diagnosis and the nature of his intellectual

limitations."

41. In conducting the evaluation, the evaluators reviewed: (1) Disposition Report/Case Plan Update, Superior Court of California (May 22, 2014); (2) Child Welfare Services Case Plan Update, San Joaquin County (May 22, 2014); (3) Intake Assessment, VMRC (November 13, 2013); (4) Client Assessment, Victor Group Home (May 2, 2014); (5) Transcript of Student Progress, North Valley Schools, Lodi (August 25, 2014); (6) IEP, San Joaquin County (February 21, 2014); (7) IEP, San Joaquin County (November 6, 2013); (8) Tracy Psychoeducational Assessment (December 15, 2010); (9) Lincoln Psychoeducational Assessment (April 15, 2013); (10) Mattesich Psychological Assessment (December 30, 2013); and (11) Achievement Testing, Children's Home of Stockton (April 9, 2013). The evaluators interviewed claimant, his parents, his therapist, the house manager of his group home, and the VMRC intake coordinator.

42. The evaluators administered the following tests: BASC-2, Comprehensive Test of Nonverbal Intelligence Second Edition (CTONI-2), Expressive Vocabulary Test, Second Edition (EVT-2), Peabody Picture Vocabulary Test (PPVT-4), the Prodromal Questionnaire-Brief Version (PQ-B), and UCLA PTSD Index.

43. The evaluators noted that, at the time of the testing, claimant was not taking any medications. They also noted that claimant's "current school setting notes difficulty focusing and an inability to remain seated in the classroom. He requires structured, small-group learning with behavioral supports. Recent academic testing concluded that his performance is approximately at the 2nd to 4th grade level."

44. The evaluators described claimant's behavior during the testing, in relevant part, as follows:

> [Claimant] presented as friendly and cooperative. He immediately followed this evaluator to the exam room. During testing procedures he was frequently distracted and

> needed prompting, breaks, and redirection to stay on task. [Claimant] also complained a lot during testing (being hungry, tired, bored), often got out of his seat to move around the room, started conversations about unrelated topics, and kept his hands busy with non-test related materials in the room. Each appointment was no longer than 2 hours (breaks included) as performance declined noticeably over time. He sometimes asked for clarification of instructions, and sometimes asked for feedback whether or not he got an item correct. His focus improved after he was given a concrete goal (5 minutes left, 10 more questions) or an incentive (break, snack).

45. The evaluators described the CTONI-2 as a "reliable estimate of nonverbal intellectual functioning." They stated that the Full Scale IQ "measures the general ability to perform complex nonverbal mental manipulations related to conceptualization, inductive reasoning and visualization." On the CTONI-2, claimant attained a Pictorial Scale score of 80 and a Geometric Scale score of 93 for a Full Scale IQ score of 85. The evaluators opined that, "Overall, this assessment reflects that [claimant] is functioning in the 'below average' to 'average' range of nonverbal cognitive abilities." They stated, however, that:

> It is notable that [claimant] subtest scores varied widely, between "Poor" to "Above Average." Some of the variance may be attributed to [claimant's] attention difficulties that interfere with his ability to complete tasks. In addition, [claimant] complained that he was starving, that he had a

> headache, and that he wanted a break. Nevertheless, [claimant] appeared to put forth his best efforts (i.e., despite getting out of his seat a number of times, he continued to return to the tasks with redirection from this evaluator.)

The evaluators concluded that:

> It does not appear that [claimant's] scores were adversely affected by his tendency to stray from the testing situation. Essentially, his scores did not appear to be significantly reduced due to his distractibility. The FSIQ from the CTONI-2 is also slightly higher than his performance on non-verbal subtests of the WISC-IV (PRI 73 and 75 respectively), but still below expectations for his age. Therefore, the evaluator believes that the current results are viewed as an accurate estimate of his current abilities.

46. The evaluators summarized their conclusions regarding claimant's intellectual functioning, in relevant part, as follows:

> This evaluator was unable to use the WISC-IV to assess [claimant's] cognitive functioning because it had been used recently in another evaluation. Therefore, the CTONI-2 was used to measure nonverbal aspects of [claimant's] cognitive functioning. The CTONI-2 is a measure that is independent of language, culture, and processing speed. As such, if a person struggles to pay attention or process information quickly, then their performance on the measure is not as

> negatively influenced as it would be on other measures (e.g., the WISC-IV). Results from the CTONI-2 placed [claimant's] non-verbal abilities in the 'below average' range. This score is consistent with the "borderline" scores on [claimant's] nonverbal subtests of the WISC-IV. Subtests of the CTONI-2 further suggest that [claimant] can perform better, and in the 'average' range on concrete tests (i.e., categories). However, his performance on more abstract and complex tasks (i.e., sequences and analogies) was markedly impaired.
>
> It is important to note that nonverbal abilities are only one aspect of an individual's intellectual functioning. A review of [claimant's] combined records suggests that [claimant's] overall IQ likely falls in the 'low' range (i.e., 54 to 67). While previous WISC-IV scores were reported to be negatively impacted by [claimant's] inattention, his poor attention does not sufficiently account for his lower scores across measures and settings. That is, although [claimant's] poor attention does negatively impact his ability to stay focused and learn new information, even when he is focused and attentive, his cognitive performance is far lower than would be expected for an adolescent his age.

47. In evaluating claimant's intellectual functioning, the evaluators also took into account claimant's adaptive functioning. The evaluators relied upon the information that claimant's parents provided that claimant "has been behind his peers in various domains (i.e., language, academic skills, social skills) since birth and the gap in

functioning has continued to grow with age." The evaluators noted further that claimant presented "as developmentally immature to his house manager, therapist and this evaluator." In addition, the evaluators found that "[r]ecords and reports further show poor functioning with regard to social skills, safety, and functional communication."

48. With regard to claimant's intellectual functioning, the evaluators concluded:

> Given [claimant's] low cognitive and adaptive functioning (detailed above) a primary diagnosis of **Intellectual Disability, Mild** (ID; previously Mild Mental Retardation in the DSM-IV TR) is offered. It should be noted that IQ score is only one aspect of a diagnosis of Intellectual Disability. Clinical judgment must be used to place scores within context, especially when there is variability in scores. Despite some intermittently higher scores, [claimant] has consistently displayed severe impairment in adaptive functioning, and continuously struggles with complex and abstract comprehension and reasoning. A diagnosis of ID best reflects his current functioning and service needs. (Bolding in original.)

49. The evaluators made a "secondary diagnosis of **Attention-Deficit/Hyperactivity Disorder** (ADHD)" explaining that, in the event that claimant's "ADHD symptoms are effectively treated, it is expected that [claimant] would still have executive functioning and impulse control problems associated with ID." (Bolding in original.) They also made a "tertiary diagnosis of **Conduct Disorder**." (Bolding in original.) They stated that, "Although Conduct Disorder is not [claimant's] primary

diagnosis, getting disruptive behaviors under control, in particular those that present life threatening risk, must be a primary goal of intervention."

50. The evaluators recommended that claimant would "benefit from remaining in a highly structured residential care facility until he can reliably implement basic coping skills to manage his impulsivity, anger and aggression." With regard to claimant's treatment needs, the evaluators found that, because claimant's "disruptive behaviors are severe, and warrant immediate and intensive treatment to prevent harm to others in both home and community settings," the evaluators recommended that "an intensive family and community-based treatment program that offers individual treatment, behavioral management and caregiver support should be put in place."

51. The evaluators also suggested that the evaluation be shared with claimant's treating psychiatrist, who can "help determine if medication can assist [claimant] with better managing his distractibility and impulsivity." The evaluators noted that, "Given previous concerns about medication management, care should be taken to consider potential risks and benefits of various medications and combinations thereof."

DR. JOHNSON'S TESTIMONY REGARDING CLAIMANT'S EVALUATIONS AND ASSESSMENTS

52. Dr. Johnson is a Clinical Psychologist. She is also a licensed Marriage and Family Therapist. She has been employed as a Clinical Psychologist at VMRC for about four years. Prior to working at VMRC, she worked for the Stanislaus County Department of Mental Health for 17 years. Part of her duties when she worked for the County included evaluating inmates for intellectual disabilities.

53. At the hearing, Dr. Johnson reviewed and analyzed in detail the evaluations and assessments described above. Dr. Johnson explained that developmental delays are generally seen in individuals with intellectual disabilities early in their lives. But in claimant's case, as set forth in the records, claimant reached

developmental milestones in the early part of his life, and the onset of severe and chronic psychiatric disorders preceded his decline in intellectual ability. Dr. Johnson opined that the evaluations and assessments, when read as a whole, show that claimant's psychiatric impairments have negatively impacted his learning ability.

54. In reaching her conclusions, Dr. Johnson pointed to the Psychoeducational Assessment conducted by Tracy in 2005 when claimant was six years old. That assessment indicated that claimant was diagnosed with ADHD when he was five. Because of claimant's "extreme difficulty in sustaining attention," the assessment had to be conducted over five days. The assessors opined that, given this extreme difficulty, the results represented a "mild underestimate of his skills and abilities." But even with this difficulty, claimant attained a Full Scale IQ score of 84, well above the score of 70 or below, which is usually used to identify an individual with an intellectual disability. Moreover, Dr. Johnson pointed out that the school district identified claimant as qualifying for Special Education services under the category of Other Health Impairment due to his ADHD. It did not identify claimant as qualifying for such services under the category of Intellectual Disability.

55. Dr. Johnson noted that, in general, none of the school district assessments identified claimant as an individual with an intellectual disability. Throughout these assessments, claimant's challenges with distractibility and behavioral and emotional problems were noted. Claimant's scores on the tests given by the school districts showed that claimant had "splintered" abilities: his verbal and working memory scores were significantly lower than his other scores indicating that his inability to sustain attention was impacting his intellectual functioning. The assessors opined that, given his psychiatric conditions, the scores claimant attained on intellectual testing underestimated his actual intellectual functioning.

56. Dr. Johnson raised concerns with Dr. Maples' diagnosis in March 2014 of Mild Mental Retardation. In particular, Dr. Johnson testified that there was no objective data included in Dr. Maples' letter to support his "diagnostic impression."

57. Dr. Johnson also raised concerns with the Psychological Evaluation conducted at U.C. Davis in August and September 2014. Dr. Johnson noted that the first record listed on the evaluation was dated December 15, 2010. Thus, it appeared that the evaluators did not review or consider claimant's low average level of cognitive functioning when he was six years old. In addition, Dr. Johnson was concerned that, although the evaluators noted that claimant was "frequently distracted and needed prompting, breaks, and redirection to stay on task," unlike the previous assessors and evaluators, they did not find that these behaviors caused claimant's scores to underestimate his true cognitive abilities. Dr. Johnson questioned further the evaluators' analysis of claimant's score on the CTONI-2 test. On that test, claimant achieved a score of 85, which placed him in the low average range, well above a score of 70 or below, which is usually used to identify an individual with an intellectual disability. Dr. Johnson also pointed to information in the evaluation which indicated that claimant appeared to function best in a group home for extremely emotionally disturbed youth, which suggested that he was receiving treatment appropriate to his mental health issues. In addition, the services which the evaluators recommended for claimant were focused on addressing his emotional and psychiatric issues, and were not the types of services usually provided to individuals with an intellectual disability.

58. Dr. Johnson could not definitively opine about how claimant's test taking may have been affected by the medications he was taking. According to Dr. Johnson, psychotropic medications that are not helping an individual may artificially deflate an individual's IQ scores. But medications that are appropriate for an individual may help him take the test and achieve his cognitive potential.

59. In sum, Dr. Johnson noted that at both six and 16 years of age, claimant tested in the low average range of intellectual functioning. She opined that, when all the assessments and evaluations are reviewed, and the totality of the information, including claimant's test results, adaptive functioning, clinical interviews, evaluators' observations, and claimant's other records, is considered, claimant's impaired intellectual functioning originated as and is solely a result of his psychiatric disorders. As such, claimant is excluded from receiving services from VMRC.

MOTHER'S AND STEPMOTHER'S TESTIMONY

60. Claimant's mother and stepmother testified at hearing. Claimant's representatives did not call any expert witnesses to testify in this matter.

61. Claimant's Mother. Claimant's mother testified that she wanted to understand where claimant stands so he can obtain all the services he needs to be able to function independently after she is gone. She stated that she knew from his first cry that something was wrong with him. She believes that claimant has an intellectual disability that prevents him from fully functioning as an adult. She also believes that claimant was wrongly diagnosed with psychiatric conditions and that she mistakenly allowed him to be medicated. She feels that claimant's aggressive behaviors were the result of too much medication. She believes that the "best thing" she did for him was to get him off all medications. She testified to the various conversations she has had with his healthcare providers and evaluators over time about claimant, which are not reflected in the records that were submitted into evidence. She stated that claimant was currently on the diploma track at school, but since he was failing all his classes, he was going to be placed on the certificate track. She questioned the "prompting" that teachers gave him when he took various tests at school, which may have elevated his scores. She believes that claimant would benefit from the services that VMRC can provide, as opposed to the mental health services he now receives.

62. Claimant's mother argued that claimant is substantially disabled as that term is defined in California Code of Regulations, title 17, section 54001, because he has significant limitations in the areas of learning, self-care, self-direction, capacity for independent living, and economic self-sufficiency. She argued further that claimant's test scores at six years old should be disregarded because he was too young for his IQ to be adequately determined. She pointed to claimant's IQ scores that fell between 54 and 67 as showing that he has an intellectual disability. She asserted that, without the services that VMRC can provide, claimant would not have a chance to be successful in life.

63. Claimant's Stepmother. Claimant's stepmother testified that the school district assessors placed claimant in the Special Education categories they did in order for their districts to obtain funding. She asserted that the testing that was done when claimant was six years old should be disregarded because he was too young at that time to properly be assessed. She recognized that claimant's "splintered" scores in areas involving visual and "kinesthetic" learning may have been higher than his other scores, but that was just because those areas were "his spark." But she asserted that VMRC could not rely on the higher scores in these areas to establish that claimant's intellectual functioning was not in the disabled range. She asserted that, because Dr. Maples saw claimant two to three times a week for six months while claimant was in Juvenile Hall, his impressions should be given weight. She believed that the medications claimant was taking caused him to engage in the angry and aggressive behavior. She asserted that now that claimant is off all medications, it is clear that his cognitive deficits are the result of his intellectual disability, and that, due to his intellectual disability, he is unable to live on his own and take care of himself.

DISCUSSION

64. Regional centers provide services to individuals who have a

"developmental disability" as defined in the Lanterman Act. The developmental disabilities described in the Lanterman Act include intellectual disability and a disabling condition that is closely related to intellectual disability or requires treatment similar to that required for individuals with an intellectual disability (generally referred to as the "fifth category"). (Welf. & Inst. Code, § 4512, subd. (a).) But individuals whose intellectual impairments are solely the result of psychiatric disorders or treatment given for such disorders are excluded from receiving services from regional centers. (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1).)

65. When all the evidence is considered, the testimony of Dr. Johnson that claimant's intellectual impairments are solely the result of his psychiatric disorders was persuasive. The school district assessments that Dr. Johnson relied upon in reaching her conclusions are thorough, consistent, and carefully reasoned. They summarize the significant amount of testing that the school districts conducted. They detail the observed behaviors of claimant. There is no indication in these assessments that the assessors were motivated by financial or other inappropriate considerations in reaching their conclusions. The school district assessors questioned whether claimant's extreme attention problems adversely affected his ability to take the tests, therefore causing his scores to underestimate his cognitive potential. None of the school district assessors identified claimant as a child with an intellectual disability. Instead, they found that claimant's ADHD and other mental health conditions allowed him to receive Special Education services under the category of Other Health Impairment. Tracy also found that claimant qualified for Special Education services under the category of Specific Learning Disability, and Lincoln found that claimant qualified for Special Education services under the category of Emotional Disturbance.

66. In contrast, as Dr. Johnson testified, the evaluation done by U.C. Davis contains inconsistencies and gaps that prevent it from being relied upon. The

evaluators' discounting of claimant's Full Scale IQ score of 85 on the CTONI-2 is not persuasive. That score placed claimant in the low average range of cognitive functioning, not in the intellectually disabled range. The evaluators' determination that the earlier IQ scores of 54 to 67 should be accepted instead of the score of 85 they measured runs counter to the concerns raised by the assessors and evaluators whose tests measured those scores that claimant's extreme distractibility and psychiatric conditions may have caused claimant's true cognitive abilities to be underestimated. In addition, the evaluators failed to take into account the higher IQ scores claimant attained when he was six years old. Furthermore, the services recommended by the U.C. Davis evaluators are those generally recommended for individuals with emotional and psychiatric issues, and are not the types of services usually provided to individuals with an intellectual disability. Given these unexplained inconsistencies, the U.C. Davis evaluation cannot be given much weight.

67. As Dr. Johnson explained, the impressions reached by Dr. Maples, Dr. Moghaddam, Sierra Vista Hospital, and the Kaiser healthcare providers that claimant has an intellectual disability must also be given little weight because there is no indication that there was any intellectual testing conducted to reach these impressions, and these impressions were not supported by sufficient data.

68. Claimant's mother believes that the psychotropic medications that claimant was taking may have adversely impacted his scores, and that may be the case. As set forth in Dr. Mattesich's evaluation, the medications may have caused claimant's scores to be artificially deflated. While it is true that claimant's scores were significantly higher when he was not taking psychotropic medications – placing him in the low average range when tested by U.C. Davis – the conclusion that claimant is both better off and intellectually disabled when he is not medicated is not supported by the totality of the evidence. The U.C. Davis evaluators noted the significant attention difficulties

claimant experienced when they examined him, causing them to spread the testing over multiple days. They questioned whether the right amount and type of medication might actually help claimant better cope and function. Because claimant was not on any medication at the time of the U.C. Davis evaluation, it cannot be determined whether his IQ score may have been higher if he were appropriately medicated.

69. It is also recognized that an individual may have co-morbid diagnoses that include both intellectual disability and other psychiatric conditions, including ADHD. But given claimant's IQ testing in the low average range when he was both six and 16, the totality of the evidence supported that claimant's impaired intellectual functioning was solely the result of his psychiatric conditions and/or the treatment he may have received for those conditions, thereby precluding claimant from receiving services under the Lanterman Act.

70. It was apparent at the hearing that claimant's mother and stepmother were seeking services from VMRC in an effort help claimant achieve his highest potential. The legislature, however, made the determination that only individuals with one or more of the five specified types of disabling conditions identified in the Lanterman Act are eligible for services from regional centers. The legislature chose not to grant services to individuals who may have other types of disabling conditions, including mental health disorders, if they cannot show that they fall within one of the five categories delineated in the Act. Although the result may seem harsh, particularly for individuals with ADHD and mental health issues as serious as claimant's, the legislature did not grant regional centers the authority to provide services to individuals whose disabilities fall outside the five specified categories. Because the totality of the evidence established that claimant's impaired intellectual functioning was solely the result of his psychiatric disorders and/or treatment given for those disorders, claimant's mother and stepmother did not establish that claimant is eligible for services under the

Lanterman Act. Consequently, their request for services from VMRC must be denied.

LEGAL CONCLUSIONS

1. Under the Lanterman Act, regional centers provide services to individuals with developmental disabilities. As defined in Welfare and Institutions Code section 4512, subdivision (a), a "developmental disability" is:

> a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

2. California Code of Regulations, title 17, section 54000, subdivision (c)(1), excludes from the definition of developmental disabilities handicapping conditions that are solely the result of psychiatric disorders, and provides as follows:

> (c) Developmental Disability shall not include handicapping conditions that are:
>
> (1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result

> of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

In addition, subdivision (c)(2) excludes from the definition of developmental disabilities handicapping conditions that are solely the result of learning disabilities.

3. As set forth in the Findings, the evidence presented at hearing showed that claimant's impaired intellectual functioning was solely the result of his psychiatric disorders and/or the treatment he was given for such disorders. Consequently, under California Code of Regulations, title 17, section 54000, subdivision (c)(1), claimant is excluded from receiving services from VMRC. Claimant's appeal must therefore be denied.

ORDER

Claimant's appeal is DENIED. Valley Mountain Regional Center's denial of services to claimant under the Lanterman Act is SUSTAINED.

DATED: April 14, 2015

/s/

KAREN J. BRANDT

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)