BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2017061273

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on March 13, 2018, in Alhambra, California. Claimant was represented by his father and authorized representative.[1] Eastern Los Angeles Regional Center (Service Agency or ELARC) was represented by Jacob Romero, Fair Hearing Coordinator.

Oral and documentary evidence was received, and argument was heard.[2]

[1] Claimant's and his father's names are omitted throughout this Decision to protect their privacy.

[2] A Spanish language interpreter had been requested to assist Claimant's mother at the fair hearing. However, Claimant's mother did not attend the fair hearing, and Claimant's father confirmed that he did not need the assistance of the Spanish language interpreter.

The record was closed, and the matter was submitted for decision on March 13, 2018.

ISSUE

Does Claimant have a developmental disability entitling him to receive regional center services?

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EVIDENCE

Documentary: Service Agency exhibits 1-16.

Testimonial: Randi E. Bienstock, Psy. D.; Claimant's father.

FACTUAL FINDINGS

1. Claimant is a 24-year-old male. He seeks eligibility for regional center services based on either a diagnosis of Autism Spectrum Disorder or Intellectual Disability or under the "fifth category" of eligibility.[3]

2. On May 22, 2017, ELARC sent a letter to Claimant informing him that ELARC had determined he is not eligible for regional center services. Claimant requested a fair hearing.

CLAIMANT'S DOCUMENTED HISTORY

3. Claimant was born full term and met developmental milestones (e.g., he sat at six months, spoke first words at eight months, and walked at 12 months). He has no history of cerebral palsy or epilepsy.

4. During school, Claimant was frequently absent, performed poorly, did not complete assignments, and was defiant and withdrawn.

[3] For an explanation of "fifth category" eligibility, see Legal Conclusion 5.

5. On March 19, 2008, Claimant's mother sought psychiatric evaluation and treatment for Claimant at the Clinica Medica Montecristo in Los Angeles. She reported that Claimant was having behavior problems.

6. Claimant was admitted to Los Angeles County University of Southern California Medical Center (County USC) after a fall and head trauma on January 30, 2011. Imaging showed a small calcification in the right temporal lobe, and Claimant was referred for a brain magnetic resonance imaging (MRI). Findings on neurological examination were normal.

7. Claimant has a history of juvenile detention, and he graduated from high school while detained at juvenile hall.

8. In a letter dated January 30, 2017, Claimant's parents sent a letter to ELARC requesting an autism evaluation. They noted that when Claimant was a toddler he would sort, stack, or place items in rows. During his development, Claimant had difficulty with social interaction, lacked empathy, and was sensitive to sounds, sunlight, and smells. Claimant currently suffers from anxiety and depression, continues to struggle with social interaction, and does not care about his hygiene.

CLAIMANT'S EVALUATION

9A. On February 9, 2017, on referral by ELARC, licensed clinical psychologist Heike Ballmaier, Psy.D., B.C.B.A., conducted a psychological evaluation of Claimant (23 years old at the time) to determine his cognitive and adaptive functioning and to assess for possible Autism Spectrum Disorder (ASD). Claimant was accompanied by his parents. As part of the evaluation, Dr. Ballmaier reviewed records submitted by Claimant, including records from County USC, Clinica Medica Montecristo, and Claimant's former high school. She also reviewed Claimant's parents' letter dated January 30, 2017.

9B. Dr. Ballmaier documented her evaluation findings in a report provided to ELARC. Her findings are set forth below in Factual Findings 10 through 17.

10. When Dr. Ballmaier greeted Claimant he did not smile but exhibited adequate eye contact. During testing he was cooperative but appeared withdrawn and subdued. He did not appear easily distracted or confused. Dr. Ballmaier noted:

> [H]is social demeanor and quality of verbal interactions were not obviously odd to clearly reflect significant deficits across areas of social communication and restricted repetitive behaviors. . . . He overall did not present however as a sociable and talkative young adult. [Claimant] continued to demonstrate good eye contact however his range of facial expressions and use of appropriate gestures and index finger pointing were somewhat limited. [Claimant] did not spontaneously initiate conversation with the examiner but his enunciations were clear. He . . . engaged in limited social referencing and shared enjoyment with the examiner. He was however able to follow the examiner's gaze.

(Exhibit 7, p. 3.)

11. To assess Claimant's cognitive functioning, Dr. Ballmaier administered the Wechsler Abbreviated Scale of Intelligence – Second Edition (WASI-2). On the Verbal Comprehension Index he scored in the average range

(standard score of 94), and on the Perceptual Reasoning Index he scored in the low average range (standard scare of 86). Dr. Ballmaier noted "no significant discrepancies across index or subtest scores." (Exhibit 7, p.4.) Claimant's Full Scale Intelligence Quotient (IQ) was in the low average range (standard score of 88).

12. To assess Claimant's academic functioning, Dr. Ballmaier administered the Wide Range Achievement Test – Revision 4 (WRAT-4). Claimant's performance in Reading was in the average range (standard score of 99), but his score for Math Computation was in the deficient range (standard score of 56). Consequently, his computation skills were at a second grade level.

13. To assess Claimant's adaptive functioning, Dr. Ballmaier administered the Adaptive Behavior Assessment System – Third Edition (ABAS-3), with Claimant and his parents providing the responses. All of Claimant's adaptive skills were in the extremely low range. Regarding Claimant's social skills, Claimant's parents reported that Claimant never laughs in response to a joke, never congratulates others when something good happens to them, never shows sympathy for others when they are sad or upset, and never seeks friendships with others in his age group. Regarding Claimant's communication skills, Claimant's parents reported that he never greets others, never speaks clearly, never makes good eye contact, and never nods or smiles to encourage others when they are talking. However, during the evaluation Claimant was able to speak in simple phrases and sentences with no significant communication abnormalities. According to his parents' report, Claimant does not: independently travel in the community; follow directions; make appointments by telephone; make simple meals; use electrical appliances; take out the trash; use caution around hot or dangerous items; bathe daily; or get out of bed by himself. He needs reminders to perform daily hygiene and grooming tasks and to select correct clothes for hot

or cold days.

14A. To address autism concerns, Dr. Ballmaier administered the Autism Diagnostic Observation Schedule - Module 2 (ADOS-2), an observational assessment of Autism Spectrum Disorders. Dr. Ballmaier noted that Claimant's overall score fell in the "autism spectrum" range. (Exhibit 7, p. 10.) However, Dr. Ballmaier explained, "This means that examiner ratings reflected some symptoms on the Autism Spectrum but did not fully reach into the Autism range." (*Id.* at p. 5.)

14B. Dr. Ballmaier observed:

> [Claimant] did not use words or phrases in a stereotyped fashion and a basic conversational exchange was possible, albeit limited. [Claimant] spoke in a monotone voice however and did not spontaneously offer any information. His use of gestures was also somewhat reduced. . . . Regarding Reciprocal Interactions [Claimant] was able to make and maintain eye contact with the examiner but his facial expressions were limited and the quality of social responses and social overtures was not obviously odd but somewhat limited. . . . No stereotyped behaviors or restricted interests were observed.

(Exhibit 7, pp. 5-6.)

15A. Dr. Ballmaier also administered the Autism Spectrum Rating Scales to Claimant's parents as reporters, with results indicating "very elevated ratings in

the areas of Social Communication, Unusual Behaviors, the DSM-5 Scale, Peer Socialization, Atypical Language, Stereotypy, and Behavioral Rigidity." (Exhibit 7, p.6.) Specifically, Claimant's parents reported that Claimant "never sought the company of other children and never shared fun activities with others, avoided looking at others when speaking to them, did not understand the point of view of others, . . . never showed an interest in the ideas of others, never smiled appropriately, and always chose to play alone. . . . In terms of Restricted Repetitive Behaviors [Claimant] reportedly used to flap his hands as a young child, [and] needed for things to happen just as expected, used to line up objects. . . ." (*Ibid.*)

15B. Although Claimant's parents "reported many Autism-like characteristics," Dr. Ballmaier opined that "more documentation (e.g., school records) is necessary to corroborate their report, given that few characteristics were observed during [the evaluation] session that clearly reflected characteristics that are considered exclusive to Autism and did not suggest the possible presence of other mental health disorders (such as the prodromal symptoms of a psychotic disorder)." (Exhibit 7, p. 6.)

16. Dr. Ballmaier diagnosed Claimant with a Specific Learning Disorder, with impairment in Mathematics. She explained this diagnosis, stating: "A significant discrepancy appears to be present between low average cognitive skills and mathematical ability that indicated a second grade level of functioning." (Exhibit 7, p. 7.) Dr. Ballmaier included the following diagnostic considerations: "Rule out Psychotic Disorder and/or Mood Disorder;" "Rule out Social Communication Disorder;" and "Rule Out [ASD]." (*Ibid.*) Dr. Ballmaier explained that she had not ruled out ASD as a diagnosis because, despite Claimant's reported deficits in pragmatic use of communication and his inability to establish

and maintain meaningful social relationships, "[h]is presentation during [the] assessment did not clearly indicate the presence of a full diagnosis of [ASD]." (*Ibid.*) Additionally, "background history was sketchy and no historical records were available to further describe his past strengths and challenges." (*Ibid.*)

17. Dr. Ballmaier recommended:

1. Educational records should be obtained to assess [Claimant's] academic, communicative skills and social functioning and to obtain a better understanding of his skills and weaknesses during the developmental period.
2. [Claimant] should receive a mental health assessment to rule out the presence of a psychotic and /or mood disorder.
3. [Claimant] and his family should contact the Department of Rehabilitation to assess his job interests and to receive vocational training and experience in a field he might be interested in.

(Exhibit 7, pp. 7-8.)

ELARC'S ELIGIBILITY DETERMINATION

18A. After Dr. Ballmaier completed her psychological evaluation, Randi E. Bienstock, Psy.D. was asked by ELARC to provide input as part of the interdisciplinary eligibility team. Dr. Bienstock reviewed Dr. Ballmaier's evaluation report and the documents which Claimant had submitted prior to Dr. Ballmaier's evaluation.

18B. On May 16, 2017, Dr. Bienstock prepared a Psychologist Record Review summarizing her findings. She noted that Dr. Ballmaier found no diagnoses of Intellectual Disability or ASD under the DSM-5.[4] Dr. Bienstock

[4] At the fair hearing, the Administrative Law Judge took official notice of

concluded that Claimant was not eligible for regional center services based on review of all available information.

19. After Dr. Bienstock's initial records review, Claimant's parents submitted additional documentation which Dr. Bienstock also reviewed. These included documents from: the Ohio Department of Mental Health and Addiction Services, Summit Behavioral Healthcare; the Los Angeles County Department of Mental Health, Exodus Recovery Urgent Care; and County USC Neurology Clinic.

20A. According to the records from the Ohio Department of Mental Health and Addiction Services, Summit Behavioral Healthcare, Claimant reportedly moved to Ohio in about 2011. In August 2013, he was arrested and charged with Felonious Assault (Deadly Weapon) and Felonious Assault (Serious Harm). Claimant remained incarcerated or hospitalized following his arrest. He was hospitalized at Summit Behavioral Healthcare (Summit) from June 25, 2014 through July 14, 2014 to undergo a competency evaluation. He was deemed competent to stand trial, and he was returned to incarceration. While in custody, Clamant was mostly quiet but exhibited episodes of "yelling, smearing feces, spitting, and throwing both urine and feces." (Exhibit 9, p. 3.) In April 2016, Claimant was found incompetent to stand trial, but "restorable." (Exhibit 9, p. 17.)

20B. From April 20, 2016 through November 9, 2016, Claimant was again hospitalized at Summit to undergo Restoration of Competency treatment as ordered by the criminal court. Claimant's admitting diagnosis at Summit was "Psychotic Disorder, not otherwise specified," and "Alcohol and cannabis use disorder, in a controlled environment." (Exhibit 9, p. 3.)

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the Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. (DSM-5) as a generally accepted tool for diagnosing mental and developmental disorders.

20C. According to Summit records, Claimant reported that he began using alcohol and marijuana as a teenager and that he previously enrolled in, but failed to complete, three outpatient substance abuse programs in Los Angeles. Claimant's history of criminal charges included criminal trespass, possession of drugs, assault, obstruction of official business, resisting arrest, and possession of drug abuse instruments.

20D. During his 2016 Summit hospitalization, Claimant "was initially very psychotic and unpredictable." (Exhibit 9, p. 4.) The Summit records detailed Claimant's numerous psychiatric difficulties, examples of which are as follows: At the time of his admission, when he was asked questions, "he appeared to have some thought blocking and he frequently looked away and smiled inappropriately. His responses were often very brief as well and they occasionally had nothing to do with the question asked. When his inappropriate smiling was pointed out to him, he claimed that he was having funny thoughts. He was asked what the funny thoughts were, and he responded with remarks such as 'trying soup.' In addition, at one point when asked his nationality, he answered, 'Aquarius.'" (Exhibit 9, p. 3.) On April 21, 2016, Claimant lunged at one of the physicians and admitted that he "was hearing a voice." (*Ibid.*) On April 22, 2016 he became threatening and agitated, resulting in the need for emergency intramuscular medications and locked seclusion. On April 28, 2016, he told a physician, "I just saw your head roll off of the desk." (*Ibid.*) On May 20, 2016, Claimant mentioned that he had "zombie disease," that he had attacked and eaten someone's face and heart, that he "love[d] to eat hearts," that he needed a Hannibal Lector mask to keep from eating people in the hospital, and that he and his family practiced cannibalism. On May 31, 2016, he expressed thoughts of harming himself and others. Claimant's dose of Abilify was increased, he had a

significant decrease in psychotic symptoms and aggressive behavior after July 26, 2016.

20E. Claimant's discharge diagnoses on November 9, 2016 were: "Schizophrenia;" and "Cannabis and alcohol use disorders, in a controlled environment." (Exhibit 9, p. 9.) Summit records did not indicate any concerns related to a diagnosis of ASD.

21. Records from the Los Angeles County Department of Mental Health, Exodus Recovery Urgent Care, and County USC indicate that, on June 26, 2017, Claimant's aunt called a hotline requesting an evaluation because Claimant was talking to himself, not sleeping, and had not showered for two months. An evaluation was conducted and Claimant was placed on involuntarily hold. A urine drug screen was positive for marijuana. Claimant was diagnosed with "Unspecified schizophrenia spectrum and other psychotic disorder [rule out] schizophrenia." (Exhibit 12, p. 8.) He was discharged on June 27, 2017 with referrals for continued care and follow-up. The records did not indicate any concerns related to a diagnosis of ASD.

22. After reviewing the additional records described above (in Factual Findings 19 through 21), Dr. Bienstock concluded that the new information did not change her opinion that Claimant is ineligible for regional center services.

23. At the fair hearing, Dr. Bienstock testified credibly on behalf of the Service Agency. She concurred with Dr. Ballmaier's determination that, based on Claimant's records and psychological evaluation, Claimant does not meet the DSM-5 criteria for diagnoses of either Intellectual Disability or ASD.

24. Claimant presented no evidence that he has ever been diagnosed with either Intellectual Disability or ASD. He also presented no evidence that he suffers from a condition similar to Intellectual Disability or requiring treatment

similar to that of people with Intellectual Disability.

25. At the fair hearing, Claimant's father insisted that Claimant "has a condition," and he did not understand why ELARC "does not want to qualify him for services." He noted that, when Claimant was a teenager, he "tried to fit into the school system," but "due to comprehension and behavior [he was] not able to make it." Claimant's father observed that Claimant "cannot act independently," and has been like that "for the past 24 years of his life." Claimant's father pointed out that Claimant "is in need of psychiatric attention and medical attention which is not [being given] to him by any institution."

26. The preponderance of the evidence did not establish that Claimant suffers from ASD, Intellectual Disability, or a condition similar to Intellectual Disability or requiring treatment similar to that of individuals with Intellectual Disability.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from a developmental disability (ASD, Intellectual Disability, or "fifth category") which would entitle him to regional center services under the Lanterman Developmental Disability Services Act (Lanterman Act).[5] (Factual Findings 1 through 26; Legal Conclusions 2 through 14.)

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. A claimant seeking to establish eligibility for government benefits or services has the burden of proving by a preponderance of the evidence that he has met the

[5] Welfare and Institutions Code section 4500 et seq.

criteria for eligibility. (*Lindsay v. San Diego Retirement Bd*. (1964) 231 Cal.App.2d 156, 161[disability benefits]; *Greatorex v. Board of Admin*. (1979) 91 Cal.App.3d 54, 57 [retirement benefits]; Evid. Code, § 500.) Where a claimant seeks to establish eligibility for regional center services, the burden is on the appealing claimant to demonstrate by a preponderance of evidence that the Service Agency's decision is incorrect and that the appealing claimant meets the eligibility criteria. Claimant has not met his burden of proof in this case.

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

> a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. . . [T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

4A. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a "substantial disability." Pursuant to Welfare and Institutions Code

section 4512, subdivision (*l*)(1):

> "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

4B. Additionally, California Code of Regulations, title 17, section 54001 states, in pertinent part:

(a) "Substantial disability" means:

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

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

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

5A. In addition to proving a "substantial disability," a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: intellectual disability, epilepsy, autism, and cerebral palsy. The fifth and last category of eligibility is listed as "Disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability." (Welf. & Inst. Code, § 4512.)

5B. Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

5C. The Legislature requires that the fifth category qualifying condition be "closely related" to intellectual disability (Welf. & Inst. Code, § 4512) or "require treatment similar to that required" for individuals with intellectual disability (Welf. & Inst. Code, § 4512). The definitive characteristics of intellectual disability include a significant degree of cognitive and adaptive deficits. Thus, to be "closely related" to intellectual disability, there must be a manifestation of cognitive and/or adaptive deficits which render that individual's disability like that

of a person with intellectual disability. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to intellectual disability. If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his performance renders him like a person with intellectual disability. Furthermore, determining whether a claimant's condition "requires treatment similar to that required" for persons with intellectual disability is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training, living skills training, speech therapy, or occupational therapy). The criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment.

6. Furthermore, in order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled either with a psychiatric disorder, a physical disorder, or a learning disability could still be eligible for services. However, someone whose conditions originate only from the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability would not be eligible.

7. The Lanterman Act and its implementing regulations contain no definition of the qualifying developmental disability of "intellectual disability." Consequently, when determining eligibility for services on the basis of intellectual disability, that qualifying disability has been defined as congruent to the DSM-5 diagnostic definition of Intellectual Disability.

8A. The DSM-5 describes Intellectual Disability as follows:

> Intellectual disability . . . is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. The following three criteria must be met:
>
> A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
> B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
> C. Onset of intellectual and adaptive deficits during the developmental period.

(DSM-5, p. 33.)

9A. The DSM-5 notes the need for assessment of both cognitive

capacity and adaptive functioning. The DSM-5 also notes that the severity of intellectual disability is determined by adaptive functioning rather than merely an IQ score. Specifically, the DSM-5 states:

> IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

(DSM-5, p. 37.)

9B. The DSM-5 also notes: "To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A." (DSM-5, p.38.)

10A. As determined by Dr. Ballmaier and confirmed by Dr. Bienstock, Claimant does not meet the criteria under the DSM-5 for a diagnosis of Intellectual Disability. Claimant's cognitive functioning has been determined to be in the low average range. Additionally, while Claimant does demonstrate global adaptive deficits, it was not established that these adaptive deficits are directly related to intellectual impairments as opposed to his diagnosed psychiatric condition. The preponderance of the evidence did not demonstrate that Claimant

qualifies for regional center services under the category of intellectual disability.

10B. Additionally, Claimant has not established that he falls under the fifth category of eligibility. Claimant's adaptive and behavioral deficits are apparently related to his psychiatric condition, and the evidence did not establish that Claimant demonstrates his deficits in such a manner that he presents as a person suffering from a condition similar to Intellectual Disability. Moreover, Claimant's behavioral problems appear to have been reduced with medication, and the evidence did not establish that Claimant requires treatment similar to that required for individuals with Intellectual Disability. Consequently, Claimant does not qualify for regional center services under the fifth category.

11. As with intellectual disability, the Lanterman Act and its implementing regulations contain no definition of the qualifying developmental disability of "autism." Consequently, when determining eligibility for services on the basis of autism, that qualifying disability has been defined as congruent to the DSM-5 definition of "Autism Spectrum Disorder."

12. The DSM-5, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of ASD, as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and

nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. [¶] . . . [¶]

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching objects, visual fascination with lights or movement). [¶] . . . [¶]

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

(DSM-5, at pp. 50-51.)

13. As determined by Dr. Ballmaier and confirmed by Dr. Bienstock, Claimant does not meet the criteria under the DSM-5 for a diagnosis of ASD. The evidence did not establish that Claimant has ever been diagnosed with ASD by any clinical psychologist. To the contrary, further documentation submitted after Dr. Ballmaier's evaluation noted Claimant's diagnoses of Schizophrenia and Cannabis and Alcohol Use Disorders, with no indication of concerns regarding ASD. Consequently, Claimant has not established that he is eligible for regional center services under the diagnosis of autism.

14. The preponderance of the evidence did not establish that Claimant is eligible to receive regional center services.

ORDER

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

DATED:

JULIE CABOS-OWEN

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.