BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT vs. SAN GABRIEL POMONA REGIONAL CENTER, Service Agency.	OAH No. 2017101019

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on December 8, 2017, in Pomona, California. Claimant was represented by his mother, who is also his authorized representative.[1] San Gabriel Pomona Regional Center (SGPRC or Service Agency) was represented by Fair Hearings Program Manager, G. Daniela Santana.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on December 8, 2017.

ISSUE

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

[1] Claimant's and his family members' names are omitted to protect their privacy.

EVIDENCE

Documentary: Service Agency Exhibits 1 - 10; Claimant Exhibits A and B.

Testimonial: G. Daniela Santana; Tricia Duncan-Hassel, Psy.D.; Claimant's mother.

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FACTUAL FINDINGS

1. Claimant is an 18-year-old male. He seeks eligibility for regional center services due to deficits in his adaptive skills.

2. On October 4, 2017, SGPRC sent a letter and a Notice of Proposed Action to Claimant's mother informing her that SGPRC had determined Claimant is not eligible for regional center services. Claimant requested a fair hearing.

3. Claimant lives with his mother. He was reportedly exposed, in utero, to heroin and was placed on methadone for heroin withdrawal shortly after his birth.

4. Claimant had previously sought and was denied eligibility through the South Central Los Angeles Regional Center. That case was closed in 1999, and no records are available.

5(a). In March and April 2007, Paul Mancillas, Ph.D. conducted neuropsychological testing on Claimant (then seven years old) to determine whether he suffered from Attention Deficit Hyperactivity Disorder (ADHD) or possible learning disorders. At that time, Claimant's parents reported that he had difficulty focusing in class and that he was unable to sit still or work independently at school or at home. They further reported that he had been pulling out his left eyelashes and picking all of his scabs.

5(b). In an April 18, 2007 report, Dr. Mancillas noted that Claimant's overall development was in the average range. He started crawling at seven months old, was

walking alone at 13 months old, and was toilet trained at 3.5 years old. His language developed normally. However, he was still unable to tie his shoes, and he continued to wet the bed at night. As an infant, he was described as hyperactive. He was also described as "uninhibited, risk-taking, and tended to avoid eye contact. He gave up quickly on tasks. He also could be irritable and had some difficulty being touched." (Exhibit 9.) At the time of Dr. Mancillas' evaluation, Claimant was attending a general education third grade class. He had never repeated a grade nor had he been placed in any special education class. However, his grades had been declining, and the school district's behavior specialist worked with him on his social skills once per week.

5(c). During the testing, Dr. Mancillas observed that Claimant was cheerful and friendly. However, Claimant was extremely hyperactive, and he had difficulty sitting still in his chair. "There were also occasions of oppositional behavior as well as poor impulse control. . . . His insight and judgment are poor. His memory is questionably intact." (Exhibit 9.)

5(d). Dr. Mancillas noted that "[p]revious testing done by the school psychologist in November 2006 yielded a Full-Scale IQ score that was in the average range (SS = 98). The Verbal Comprehension Index and the Perceptual Reasoning Index were measured in the average range as was the Processing Speed Index. The Working Memory Index measured in the average to low average range. Motor previsual perception measured below average and the test of Visual Motor Integration measured at a borderline range. Overall auditory processing skills were in the average range." (Exhibit 9.)

5(e). To assess Claimant's cognitive functioning, Dr. Mancillas administered the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV). Claimant's tests scores were generally consistent with the prior assessment. Claimant's Verbal Comprehension Index (standard score 104), Perceptual Reasoning Index (standard score

104), Processing Speed Index (standard score 103), and full scale IQ (standard score 102) were all within the average range. Similar to the prior assessment, his Working Memory Index (standard score 88) was in the low average range. Testing also revealed that Claimant's academic skills measured in the average range.

5(f). Dr. Mancillas diagnosed Claimant with ADHD, combined type.

6. As a result of his diagnosis, Claimant qualified for special educations services as a student under the category of Other Health Impairment (OHI), specifically ADHD.

7(a). In April and May 2013, Claimant underwent a psychoeducational evaluation through his school district. He was 13 years old at the time. Claimant reportedly displayed the following: "overactive, short attention span, impulsive, easily frustrated, lacks self-control, over anxious, excessive fears, underactive, peer difficulties, socially avoidant, shy, often unhappy, disruptive, unmotivated, self-mutilating, disorganized and problems with homework." (Exhibit 8.) His mother reported that he "has a history of stealing from family members, lying, has to be told to shower and take care of personal hygiene." (Exhibit 8.) He had discussed thoughts of suicide with a psychiatrist, but he had no history of attempts.

7(b). Claimant was administered several tests to determine his cognitive functioning, academic functioning, and adaptive functioning, and to assess the likelihood of autism. Claimant's cognitive skills and academic skills were measured in the average range. He was administered the Gilliam Autism Rating Scale – Second Edition (GARS-2) to identify reported behaviors which could indicate the likelihood of autism. Based on parent reporting, there was a possibility of autism, but it was not very likely. Based on teacher reporting the possibility of autism was unlikely. The school district concluded that Claimant "does not appear to qualify for special education under the classification of Autistic-Like Behaviors at this time." (Exhibit 8.)

7(c). The psychoeducational evaluation revealed that there was "a significant discrepancy . . . between [Claimant's] cognitive ability and his academic achievement in reading comprehension which seems to be due to a disorder in the areas of attention, visual processing and sensor motor processing. These processing delays seem to interfere with [Claimant's] ability to adequately process information in the general education program at this time. [¶] . . . [¶] The discrepancy is not the result of . . . mental retardation[.]" (Exhibit 8.) Claimant's school district concluded that Claimant continued to be eligible for special education services under the category of OHI due to his ADHD.

8. Claimant's 2016 Individualized Education Plan (IEP) indicates that he continues to qualify for special educations services under the primary category of OHI and under the secondary category of Specific Learning Disability (SLD).

9. In June 2017, Claimant requested an evaluation for regional center eligibility.

10(a). As part of its intake process, the Service Agency conducted a social assessment in July 2017. Intake Service Coordinator, Virginia Rodriguez-Wintz noted in the social assessment that Claimant had two hospitalizations for suicide watch. In March 2016, he was hospitalized at Charger Oak Hospital for several days, and on May 4, 2017, he was admitted to Charter Oak for one week. Claimant is currently under the care of a psychiatrist and attends weekly one-hour therapy session with clinical psychologist, Tricia Duncan-Hassell, Psy.D.

10(b). During the social assessment, Ms. Rodriguez-Wintz also noted Claimant's current adaptive functioning, which was deficient in some areas. He is fully ambulatory, and his fine motor skills are age-appropriate. Although he can make himself simple snacks and meals, his parents do not feel confident allowing him to use the stove and oven without supervision. He has complete bowel and bladder control but does not wipe well after toileting, and he does not flush or wash his hands without prompting. He

also needs reminders to brush his teeth, to wash his hair, and to scrub his body completely. Claimant does not choose weather-appropriate clothing, and he occasionally puts his clothing on backwards or inside out. He has basic safety awareness but is very trusting, and he is inclined to follow strangers with no regard for his safety.

10(c). During the social assessment, Claimant made good eye contact with Ms. Rodriguez-Wintz. His mother reported that he can be overly-friendly to the point that others are uncomfortable. He also lacks the ability to read social cues. Behaviorally, Claimant does not engage in emotional outbursts or tantrums. He does not have to follow the same routine and he accepts transitions. He does not flick his fingers, flap his hands or rock his body. He occasionally picks the skin on his arm, but that behavior is decreasing.

11(a). On August 4, 2017, licensed clinical psychologist Franklin Carvajal, Ph.D., conducted a psychological evaluation of Claimant to ascertain his level of cognitive, adaptive and social functioning in order to assist SGPRC in determining Claimant's regional center eligibility. Dr. Carvajal reviewed Claimant's records and noted that Claimant had previously been diagnosed with ADHD, Major Depressive Disorder, and Specific Learning Disorder. During the interview, Dr. Carvajal noted that Claimant "expressed some morbid topics. However, he stated he did not want to hurt himself." (Exhibit 5.) Dr. Carvajal observed, "[Claimant] was appropriately dressed and well-groomed. . . . His words were few and his replies short but appropriate. He appeared either fatigued or sad. [¶] Socially, [Claimant] was pleasant and friendly. However, he rarely smiled. [¶] During testing, [Claimant] worked steadily and diligently. He did not demonstrate aggressive behaviors even when he was frustrated. [¶] At the end of the session, [Claimant] said bye without prompting." (*Ibid.*)

11(b). To assess Claimant's cognitive functioning, Dr. Carvajal administered the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV). Claimant's general

cognitive ability was measured in the low average range (Full Scale IQ 85). His Verbal Comprehension Index was in the average range (standard score 100), his Perceptual Reasoning Index (standard score 88) and Processing Speed (standard score 81) were in the low average range, and his Working Memory was in the borderline range (standard score 77). Dr. Carvajal noted that Claimant's "abilities to sustain attention, concentrate, and exert mental control are a weakness relative to his verbal reasoning abilities. A weakness in mental control may make the processing of complex information more time-consuming for [Claimant], draining his mental energies more quickly as compared to others at his level of ability, and perhaps result in more frequent errors on a variety of learning or complex word tasks." (Exhibit 5.)

11(c). To assess Claimant's adaptive functioning, Dr. Carvajal administered the Adaptive Behavior Assessment System – Third Edition (ABAS-3), with Claimant's mother as the respondent. Claimant's mother reported Claimant's difficulties in several areas, which were noted by Dr. Carvajal as follows: "adjusting to new social situations in any environment[;] staying on task[;] has no friends[;] understanding/following directions[;] does not understand age-appropriate interests – very warped[;] hardly takes turns talking – always talks over people[;] he describes himself – funny – he's not funny – it's warped[;] he can't talk about a range of topics[;] he is always confused with most things – he says[;] takes things very literally[;] he can't allow instructions with more than 1-2 commands at a time[;] he doesn't read body language or tones – i.e., when peers are teasing him – bullying him[;] doesn't keep his eyes focused on person talking to him[;] he is unable to adjust his behavior in different social situations[;] he has compulsive behaviors[;] he is easily frustrated[; and] he is unorganized." (Exhibit 5.) Dr. Carvajal noted that Claimant's "communication abilities, including speech, vocabulary, listening, conversation, and nonverbal communication skills, are in the Extremely Low range. He functions in the Extremely Low range when performing basic academic skills such as

reading, writing, and mathematics, as well as functional skills such as taking measurements and telling time. His ability to make independent choices, exhibit self-control and take responsibility when appropriate is in the Extremely Low range." (*Ibid.*)

11(d). Dr. Carvajal concluded that Claimant "does not exhibit symptoms like those manifested by children diagnosed with Intellectual Disability." (Exhibit 5.) He noted Claimant's cognitive functioning has continually been in the low average to average range. Although Claimant demonstrated global adaptive deficits, Dr. Carvajal noted that these "could be better explained by another medical or psychological condition such as Major Depressive Disorder," and that "Major Depressive Disorder is a condition well-known to impair functioning across adaptive domains. . . . Therefore, [Claimant] should be re-tested once his Depression is controlled." (*Ibid.*)

11(e). Dr. Carvajal also concluded that Claimant "does not exhibit symptoms like those manifested by children with Autism Spectrum Disorder. The list of difficulties his mother wrote can easily be explained by a combination of ADHD and depression. ADHD children are well-known to be impulsive and not able to stay on task, including making eye contact. Depressive children are well-known to be sarcastic, dark, ironic, and pessimistic. [¶] There is absolutely no history pointing at even a hint that [Claimant] has Autism Spectrum Disorder. [¶] Lastly, [Claimant] has never exhibited any of the highly unusual, atypical repetitive, restrictive behaviors, activities or interests manifested by children with Autism Spectrum Disorder." (Exhibit 5.)

11(f). Dr. Carvajal diagnosed Claimant, by history, with ADHD, Major Depressive Disorder and Specific Learning Disability. He noted that Claimant "would benefit from interventions targeted at reported deficits in his adaptive behaviors" (Exhibit 5), and he recommended weekly psychotherapy sessions and continued parental monitoring of Claimant's intellectual, social, emotional and behavioral development.

12. On October 4, 2017, the Service Agency determined that Claimant was ineligible to receive regional center services, but recommended that Claimant continue psychotherapy sessions, continue treatment with his psychiatrist, participate in a vocational training program, and contact the Department of Rehabilitation for assistance.

13(a). Claimant's treating psychologist, Dr. Duncan-Hassel, testified credibly on Claimant's behalf. She works with Claimant's treating psychiatrist, Dr. Gillespie, who diagnosed Claimant with ADHD and Major Depression. Dr. Duncan-Hassel has been seeing Claimant in psychotherapy sessions since 2013, but she has never conducted a full psychological evaluation of Claimant.

13(b). Dr. Duncan-Hassel noted that, years earlier, Dr. Gillespie and she had both identified autism as a "rule out" diagnosis to explore later. However, neither Dr. Gillespie nor Dr. Duncan-Hassel has diagnosed Claimant with Autism Spectrum Disorder.

13(c). Dr. Duncan-Hassel pointed out that Claimant's current social functioning is deficient. He has no friends his age nor does he demonstrate any interest in forming friendships. He prefers solitary activities. Although he previously engaged in self-stimulating behavior by picking on his skin, he has been able to control this behavior through cognitive behavioral therapy and some medication. Nevertheless, this behavior may return during periods of stress.

13(d). Dr. Duncan-Hassel also noted that Claimant currently exhibits a maladaptive, restrictive interest in the cartoon, "My Little Pony," and the related group called "Bronies."[2] According to Dr. Duncan-Hassel, "fetish" has progressed to watching the "sexually deviant portion of My Little Pony" as well as other Internet pornography. Due to these interests and his impulse control issues, Claimant's parents have had to

[2] "Bronies" are male fans of the cartoon, "My Little Pony."

take away his cellular phone and revoke his computer privileges. Dr. Duncan-Hassel pointed out that Claimant has severe adaptive functioning deficits and that his deficits and maladaptive behaviors have been resistant to cognitive behavioral therapy, social skills training, and medications.

13(f). Dr. Duncan-Hassel opined that, due to his severe adaptive deficits, Claimant will never be able to function independently, and he will always need services which include assistance with activities of daily living such as shopping, hygiene and handling his money. Dr. Duncan-Hassel described Claimant's case as a "borderline case" that is "hard to qualify under his full scale IQ." She also acknowledged that she has treated people with Autism Spectrum Disorder, and Claimant "is not a typical case." She acknowledged that she is not a neuropsychologist, but opined that Claimant's difficulties are "the effects of neurodevelopmental deficits havening being born addicted to heroin."

14. Claimant's mother testified credibly on his behalf. She noted that he does not interview well since he cannot stay on topic. Consequently, he cannot obtain employment through a typical employment agency. She is hoping that the regional center system can assist him in obtaining a job. She opined that obtaining assistance from the Department of Rehabilitation (DOR) is not feasible since she believes it will entail her having to take time off work to help Claimant access the DOR services.

15. Claimant provided no evidence that any licensed clinician has diagnosed him with either Autism Spectrum Disorder or Intellectual Disability. He also provided no expert testimony to establish that he suffers from a condition similar to Intellectual Disability or requiring treatment similar to that required for individuals with Intellectual Disability.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from a developmental disability

which would entitle him to regional center services under the Lanterman Developmental Disability Services Act (Lanterman Act).[3] (Factual Findings 1 through 15; Legal Conclusions 2 through 15.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. 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 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. 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

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

> intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

4(a). To prove the existence of a qualifying 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.

4(b). 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.

5(a). In addition to proving that he suffers from 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 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.)

5(b). 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. Not all persons with sub-average functioning and impaired adaptive behavior or with learning or behavioral disabilities are eligible for services and supports under the Lanterman Act.

5(c). To be eligible for Lanterman Act services and supports under the fifth category, the condition must 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 (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under the fifty 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 individuals 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 an individual would benefit. Rather, it is whether his condition *requires* such treatment.

6. 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; 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 qualifying 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 and supports on the basis of intellectual disability, that qualifying disability has been defined as congruent to the DSM-5 diagnostic definition of Intellectual Disability.

8. 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.)

9. 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 IQ score. (*Id.* at 37.)

10. Claimant does not meet the criteria under the DSM-5 for a diagnosis of Intellectual Disability. A diagnosis of Intellectual Disability should not be assumed solely due to a particular genetic or medical condition such as prenatal exposure to heroin. To meet the criteria for a DSM-5 diagnosis of Intellectual Disability, a person must have deficits in intellectual functioning (demonstrated through clinical assessment and standardized testing), and deficits in adaptive functioning. Claimant's cognitive functioning has been determined to be in the low average to average range.

Additionally, although Claimant demonstrated global adaptive deficits, as Dr. Carvajal pointed out, these deficits "could be better explained by another medical or psychological condition such as Major Depressive Disorder," and that "Major Depressive Disorder is a condition well-known to impair functioning across adaptive domains." (Factual Finding 11.) Consequently, the preponderance of the evidence did not demonstrate that Claimant qualifies for regional center services under the category of intellectual disability.

11. Although Claimant suffers from global adaptive deficits, he has failed to establish that he demonstrates deficits in cognitive and adaptive functioning to such a degree and in such a manner that he presents as a person suffering from a condition similar to Intellectual Disability. Additionally, the evidence was insufficient to establish that Claimant currently requires treatment similar to that required for individuals with Intellectual Disability. Based on the foregoing, Claimant has not established his eligibility under the fifth category.

12. 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 and supports on the basis of autism, that qualifying disability has been defined as congruent to the DSM-5 definition of "Autism Spectrum Disorder."

13. The DSM-5, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of Autism Spectrum Disorder, 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.)

14. Claimant does not meet the criteria under the DSM-5 for a diagnosis of Autism Spectrum Disorder. After conducting psychological testing, Dr. Carvajal found that Claimant does not qualify for a diagnosis of Autism Spectrum Disorder. Although Dr. Duncan-Hassel noted a current "fetish" with My Little Pony and its "sexually deviant component," this appears to be a relatively recent development, and there were no prior reports of restricted, repetitive patterns of behavior, interests, or activities during Claimant's early development period or childhood. The evidence did not establish that Claimant has ever been diagnosed with Autism Spectrum Disorder by either Dr. Duncan-Hassel or any other qualified psychologist. Consequently, Claimant has not established that he is eligible for regional center services under the diagnosis of autism.

15. The preponderance of the evidence does not establish Claimant's eligibility 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 affirmed.

DATED: December 13, 2017

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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.