BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

v.

SAN ANDREAS REGIONAL CENTER, Service Agency.

OAH No. 2020110113

DECISION

Administrative Law Judge Barbara O'Hearn, State of California, Office of Administrative Hearings, heard this matter by videoconference and telephone on December 11, 2020.

Claimant was present and represented by his mother, Yvonne Garcia.

Fair Hearing representative James Elliott represented the San Andreas Regional Center, the service agency.

The matter was submitted for decision on December 11, 2020.

ISSUE

Is claimant eligible for regional center services due to a developmental disability?

FACTUAL FINDINGS

Claimant History

CHILDHOOD YEARS

1. Claimant was born in February 1992. During the first few years of his life, he did not demonstrate stereotyped repetitive behaviors, restrictive or fixed interests, or unusual sensory issues. When he was three years old, claimant witnessed his biological father stab claimant's mother with a three-foot-long sword.

2. When claimant was in kindergarten, he had difficulty learning to read. In 1999, claimant's diagnostic impressions were post-traumatic stress disorder (PTSD) and a learning disorder. Medical records referred to his full scale IQ (90) as average.

3. In 2002, claimant was diagnosed with attention deficit hyperactivity disorder (ADHD) and was reported to interact appropriately when he took his medication. In 2002, claimant's full scale IQ was 74. His lower scores on the full and other scales were thought to be attributed to his failure to take his ADHD medication and his failure to care about school.

4. Claimant began Special Education classes at the beginning of second grade. At that time, claimant lived with his mother and stepfather, and his three brothers, including two half-siblings.

5. For claimant's initial and following special education assessments, his mother competed a checklist of claimant's behaviors. Although the checklist is designed to pick up autistic-like features, claimant was not found to be in that category. His special education category was "SLD" (learning disability).

6. Claimant's fifth grade teacher reported that claimant was working mostly at a third grade level in academic subjects, and higher in math. Claimant acted socially appropriate when on medication.

TEENAGE YEARS

7. Claimant's special education category was changed to "SED" (emotionally disturbed). In September 2005, when claimant was 13 years old, claimant's mother was concerned about claimant's social difficulties and academic problems. Claimant's pediatrician, Suzanne Frank, M.D., diagnosed claimant with pervasive developmental delay (PDD) and referred claimant to the Autism Spectrum Disorders Center at Kaiser Permanente.

8. The referral in 2005 determined that claimant had PDD not otherwise specified (NOS) and borderline intellectual functioning. (See Findings 22 through 24.)

9. Claimant began using marijuana when he was about 14 years old (2006). In November 2006, he was held in juvenile detention on allegations of abuse of his siblings. His stepfather was incarcerated beginning that year. In February 2007, a juvenile court social worker reported that claimant had continued exposure to domestic violence through the years, as well as his stepfather's drug use and unpredictable behavior.

10. The social worker determined that this exposure contributed to claimant's diagnosis of conduct disorder and hyperactivity. Claimant expressed a willingness to participate in services such as counseling to help prevent his inappropriate behavior.

11. In 2008, claimant was on probation, living in a group home placement. Claimant did not complete high school. His reading was at sixth grade level. In 2009, his IQ was 78. His diagnoses included ADHD, PDD NOS, intermittent explosive disorder, victim of child abuse (by stepfather), and borderline intellectual functioning.

12. In 2009, after he returned home, claimant was detained for threatening his mother. In August 2009, D. Ashley Cohen, Ph.D., performed a psychological evaluation. (See Findings 25 through 28.) In September 2009, Marilyn D. Wright, M.D., recommended that claimant continue his ADHD medication and continue further evaluation of reported anxiety. After claimant returned home, his mother noted a significant positive change, allowing claimant to be removed from electronic monitoring.

ADULTHOOD

13. As claimant grew into adulthood (2010), his ability to communicate worsened. Sometimes, he simply stopped speaking and only used physical gestures.

14. In 2010, claimant had a daughter. He spent time with her even when he and the child's mother were not a couple.

15. In about February 2013, claimant's mother requested an intake assessment by SARC for claimant. On March 5, 2013, SARC determined it was unable to offer claimant an intake because a review of his past records, as well as current

testing at that time, were not consistent with mental retardation.[1] Moreover, claimant had not been diagnosed with an autistic disorder.

16. In 2013, claimant was hospitalized for five days in a psychiatric facility due to odd and dangerous behavior. His diagnoses included schizoaffective disorder (SAD) and cannabis use disorder. In 2014, he again was hospitalized for dangerous and unusual behavior. His symptoms became worse when he used marijuana. His diagnoses included PTSD, SAD, a history of Asperger's syndrome (a type of autism) and of obsessive compulsive disorder (OCD). As he was using marijuana and alcohol daily, claimant was discharged to a sober living environment.

17. In 2014, claimant sought eligibility for regional center services due to a developmental disability. On August 27, 2014, SARC determined that claimant was not eligible for services under an autism spectrum disorder. In January 2015, SARC agreed to reassess claimant for services under an intellectual disability. (See Findings 29 through 33.)

18. In February 2015, claimant was hospitalized for acute psychiatric services. Claimant had delusions, auditory hallucinations, and paranoia. His diagnoses included PTSD, SAD, cannabis dependence, unspecified intellectual disabilities, unspecified persistent mental disorders due to noncompliance with medical treatment and other conditions.

19. After living in a recovery type home and attending AA meetings, claimant returned home sometime afterwards. In March 2015, claimant was detained for

[1] The term "intellectual disability" later replaced this term.

threatening his mother and hospitalized for six days. The same month, he was charged with felony burglary.

20. On May 18, 2015, SARC determined that claimant did not meet the criteria for eligibility criteria under autism spectrum disorder (ASD) for regional center services. This decision was not appealed.

21. In late 2019, claimant requested a redetermination of SARC's 2015 decision. It was denied with a request to reapply for services and submit new information. On August 18, 2020, claimant's mother submitted an application to SARC for determination of claimant's eligibility. On October 22, 2020, SARC issued a notice of proposed action for denial of eligibility for regional center services. Claimant submitted a fair hearing request on November 3, 2020, and this hearing followed.

Assessments and Evaluations

2005

22. Clinical psychologist Thomas Crawford, Ph.D., performed claimant's 2005 evaluation on referral from claimant's pediatrician. In his evaluation summary, he noted that, in addition to ADHD diagnosed in 2002, claimant was diagnosed with PTSD following a traumatic incident at age three and a half (witnessing abuse of his mother by his biological father). Dr. Crawford's report noted that claimant was verbally fluent, but "displayed difficulties" participating in a conversation.

23. Dr. Crawford's report summarized that claimant's "scores on the Communication domain just met the 'Autism' cut-off and his scores on the Reciprocal Social Interaction domain only just met the 'autism spectrum' cut-off." He added that

the combined score of these two domains "just met the Combined score cut-off for 'autism spectrum.'"

24. Dr. Crawford's report summarized that the deficits were consistent with an autism spectrum disorder (ASD). His impression under the Diagnostic and Statistical Manual of Mental Disorders,[2] Fourth Edition (DSM-IV), axis I, was that claimant had PDD NOS and under axis II, he had borderline intellectual functioning (per previous testing). He referred claimant for case management and parent counseling regarding the diagnosis of PPD NOS, learning disorders, and ADHD symptoms.

2009

25. In August 2009, Dr. Cohen, a clinical neuropsychologist and forensic psychologist, administered tests on the claimant for a psychological evaluation for a disability claim. Dr. Cohen's report noted that claimant's intellectual functioning was within the borderline range, and his display of social judgment was very limited.

26. Claimant's mother reported to Dr. Cohen that claimant had Asperger's Disorder and previously had Oppositional Defiant Disorder. Claimant's mother also reported that claimant abused drugs and alcohol.

27. Claimant's full scale IQ was 70, with three scores in the scale within the borderline range of intellectual functioning. On the Childhood Autism Rating Scale, Dr. Cohen rated claimant in the "upper end of the mildly to moderately autistic range." Dr.

[2] The DSM, published by the American Psychiatric Association, is the principal authority for the diagnosis of mental disorders.

Cohen's diagnosis under DSM-IV, axis I, was PDD NOS and under axis II, was borderline intellectual functioning.

28. Dr. Cohen later (see Findings 45 and 46) described her August 2009 findings as being that claimant had lower intellectual functioning, autism spectrum disorder, a speech and language disorder, and learning disabilities. She added that claimant had other deficiencies, including a substance abuse problem.

2014

29. On April 29, 2014, SARC performed an intake social assessment for claimant. At that time, claimant was 22 years old. The SARC determination, issued on August 27, 2014, is based on review of claimant's intelligence testing and academics from age seven to 17, the intake meeting with claimant and his mother, and additional information from claimant's mother.

30. SARC psychologist Susan M Heimlich, Ph.D., concluded that Dr. Crawford's narrative and rating did not endorse claimant deficits in nonverbal communicative behaviors used for social interaction. In her evaluation, Dr. Heimlich also noted that "Dr. Crawford did not find stereotyped or repetitive motor movements, use of objects or speech, nor highly restricted interests abnormal in intensity or focus, nor hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment." She concluded that claimant remained "at a subclinical level with regard to a diagnosis of full autism spectrum disorder."

31. Dr. Heimlich participated in the intake meeting. Claimant's mother reported that claimant had no mental health issues prior to age 18. Claimant was taking medication for mood stabilization and for auditory hallucinations in 2014, when

he was 21. Claimant's mother was taking care of claimant due to his problems socializing and functioning properly.

32. At Dr. Heimlich's request, claimant's mother completed an assessment test in May 2014. In that test, claimant's mother reported that despite claimant's relatively strong self-care skills, somewhat adequate home living skills, and borderline health and safety skills, claimant had "a lot of areas" in which he needed help.

33. Dr. Heimlich concluded that repeated testing of claimant for concerns about an autism-related diagnosis suggested that claimant was functioning in the "borderline range of intelligence, above the level served by the Regional Center."

34. SARC held an intake planning team meeting on October 7, 2014, with claimant, claimant's mother, Dr. Heimlich, and an intake service coordinator. Dr. Heimlich reviewed her findings in August 2014, and explained how she came to those findings.

2015

35. On January 30, 2015, SARC conducted an intake social assessment for a determination of eligibility under intellectual disability. At that time, claimant was independent in all basic self-care areas. Claimant's mother reported claimant's attention span on a single activity was between five and 15 minutes and that he used marijuana weekly.

36. SARC clinical psychologist Faith Langlois-Dul, Psy.D., observed claimant on January 30, 2015, and on April 1, 2015, when claimant and his mother completed assessment tests at Dr. Langlois-Dul's request. Claimant was mostly silent, but had

good eye contact. His affect was flat. Claimant's mother reported that claimant needed training for independent living, budgeting, communication, and vocational support.

37. After reviewing records, including claimant's history (Findings 1 through 19), and interviewing claimant and claimant's mother, Dr. Langlois-Dul issued an eligibility evaluation report on April 21, 2015. Her report detailed claimant's background and records. Dr. Langlois-Dul reviewed previous assessment results that showed claimant's intellectual functioning has varied from borderline to average range.

38. Dr. Langlois-Dul's report provided a timeline of claimant's diagnoses and significant behavioral incidents from 1999 to March 2015, when claimant was hospitalized in a psychiatric facility for the fourth time. In her report, Dr. Langlois-Dul recommended that claimant would benefit from a group home that offered mental health services like cannabis abuse education, coping skills, and self-esteem groups, as well as social skills and communication groups. She also recommended that claimant continue to work with the mental health system, maintain sobriety and participate in counseling services to learn frustration management strategies to help him manage his symptoms.

39. Dr. Langlois-Dul determined that claimant did not meet the criteria for autism spectrum disorder. At a team meeting on May 15, 2015, she explained the results of her evaluation and the conditions SARC serves as defined by law.

40. On May 18, 2015, SARC issued its decision by letter from Dr. Langlois-Dul. She stated that claimant's functioning was consistent with an attention deficit disorder, for which claimant responded well to medication until he was 13 years old. There was no indication of ASD until he was 13 years old. Borderline intellectual

functioning was raised as an issue when he was 17 years old, when several factors likely played a role in the results.

41. Dr. Langlois-Dul found that claimant was not shown to demonstrate stereotyped or repetitive behaviors, restricted or fixed interests, or unusual sensory issues. Claimant had few routines in select areas of his life. She concluded that claimant did not meet the DSM-5 criteria for autism spectrum disorder, and did not meet regional center criteria for eligibility under that disorder.

2018

42. Jacklyn L. Chandler, Ph.D., performed a psychological disability evaluation of claimant for the Department of Social Services on April 11, 2018. She reviewed Dr. Wright's 2009 medical referral and Dr. Cohen's 2009 evaluation. She observed and interviewed claimant who stated that he was able to live independently and complete most activities of daily living.

43. Claimant made eye contact, but stared at Dr. Chandler during assessment testing. Dr. Chandler found claimant's speech was clear and coherent, but mechanical. Contrary to claimant's history, claimant denied to Dr. Chandler that he had any children (Finding 14), denied any legal history (Findings 9 and 12), and denied any substance abuse (Findings 9, 16 and 18).

44. Claimant's full scale IQ was 70, within the borderline range. His index scores also were within the borderline range. His childhood autistic rating scale fell within the moderately autistic range. Dr. Chandler diagnosed claimant with ASD, level one, with intellectual and language impairment.

2019

45. In connection with his prosecution on the charges described in Finding 19, the Superior Court of Santa Clara County ordered a competency examination for claimant. Dr. Cohen performed the examination. Dr. Cohen found that claimant's intellectual functioning and speech had declined since the previous evaluation 10 years earlier (described in Findings 25, 27 and 28). He observed that claimant was withdrawn with a completely flat affect and determined that he was functioning within the extremely low range of intelligence. Based on Dr. Cohen's evaluation dated June 26, 2019, the court found claimant incompetent to stand trial and dismissed the charges against him.

46. During Dr. Cohen's examination, claimant's mother reported that there were times when claimant "falls mute" for six months or more. Claimant needed prompting by his mother for daily life activities and self-care tasks such as bathing and tooth-brushing. Dr. Cohen's report concluded that claimant has intellectual disability along with other neuropsychological limitations such as impaired memory, and severe speech and language deficits, which Dr. Cohen considered to be strong traits of ASD.

47. Dr. Cohen referred to claimant's "early age at the onset of his disabilities" and determined that the "top five" problems that have troubled claimant his entire life are low IQ, severe speech and language deficits, impaired memory, and ASD. Dr. Cohen's determination is not consistent with claimant's early age history.

2020

48. In her August 2020 application to SARC for a determination of claimant's eligibility, claimant's mother reported that claimant communicated by hand gestures, staring, and speaking one or two phrase statements. She also stated that claimant did

not interact outside his family and was withdrawn, but related well with others. She noted claimant's pacing, repetitive knocking on doors, and asking the same questions

49. On September 14, 2020, SARC psychologist Dr. Langlois-Dul and SARC service coordinator Jennifer Hayes-Luong conducted an intake social assessment (by video). With claimant and his mother, they reviewed the family situation and developmental history, including current functioning. Dr. Langlois-Dul issued an eligibility evaluation report on October 19, 2020.

50. Dr. Langlois-Dul reviewed records that were available in 2015, when she previously evaluated claimant for eligibility (Findings 35 through 41). She also reviewed the 2018 and 2019 records (described in Findings 42 through 47) submitted for the current application, as well as additional records not previously obtained. Dr. Langlois-Dul noted that Dr. Cohen's determination of claimant's capacity did not involve a developmental disability assessment.

51. Dr. Langlois-Dul found that claimant did not have an indication of an ASD in his records until he was 13 years old. Prior to that age, claimant engaged in appropriate peer relationships when he took his ADHD medication.

52. Claimant did not demonstrate any behaviors associated with ASD during the early years of his life (Finding 1), when these features are usually apparent. Dr. Langlois-Dul found that claimant met only one of the five criteria: poor social-emotional reciprocity, under the DSM-5 checklist for ASD (Finding 7.A).

53. Dr. Langlois-Dul also concluded a diagnosis of intellectual disability or borderline functioning is not appropriate. In her report and testimony at the hearing, she explained that claimant's various scores over time on tests of intellectual

functioning and academic development essentially are consistent with a learning disability and ADHD, which is considered to be a mental health condition.

54. IQ does not decline over time for someone with ASD, especially verbal IQ which is stable during the individual's lifespan. Autism is not degenerative. While a decline in functioning can occur later, it may be due to mental health conditions or substance abuse, not related to ASD. Dr. Langlois-Dul determined that claimant did not meet the criteria for regional center eligibility under an intellectual disability.

DSM-5 Criteria

AUTISM SPECTRUM DISORDER

55. The DSM-IV text revision (TR) defined PDD/NOS as a "severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities" but the criteria are not met for a specific Pervasive Developmental Disorder. (DSM-IV-TR at p. 84.)

56. The DSM-5 was published in 2013. The diagnosis of PDD/NOS in the DSM-IV does not exist in the DSM-5. The "note" following the diagnostic criteria for ASD states: "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder." (DSM-5 at p. 51.)

57. There are five diagnostic criteria for ASD, with examples that are illustrative, not exhaustive, listed below as A through D:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history, depending on severity:

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, depending on severity:

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 hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of 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 development 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.)

58. The diagnostic features in the DSM state that the ASD symptoms of Criterion A and B are present from early childhood and limit or impair everyday functioning (Criteria C and D). Core diagnostic features of ASD are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties. (DSM-5 at p. 53.) The development and course in the DSM for ASD states that symptoms are typically recognized during the second year of life (12-24 months of age) but may be seen "later than 24 months if symptoms are more subtle." (DSM-5 at p. 53.)

Comorbidity

59. The DSM-5 also discusses comorbidity of ASD with other conditions, noting that many people with ASD have one or more other comorbid mental disorders. When criteria for both ASD and another disorder are met, both diagnoses should be given. (DSM-5 at pp. 58-59.)

INTELLECTUAL DISABILITY

60. The DSM-5 provides the diagnostic criteria for intellectual disability. (DSM-5 at p. 33.) The essential features of intellectual disability are deficits in general mental abilities and impairment in everyday adaptive functioning, relative to an individual's age, gender, and socio-culturally matched peers. (*Id.*, at p. 37.)

Evidence Review

61. The reports of Dr. Cohen and Dr. Chandler were submitted without their testimony. Their reports do not focus on claimant's early years, particularly when ASD symptoms are expected to be recognized.

62. Dr. Crawford diagnosed claimant in 2005 with PDD/NOS at age 13 for having just met the autism cut-off. He did not explain if or how claimant's traits he considered to be PDD were masked prior to that age.

63. Dr. Cohen's 2009 report found claimant's intelligence test scores within the borderline range. Her 2019 report concerned claimant's capacity and did not involve assessment of a developmental disability.

64. Claimant's mother believes that she simply did not recognize ASD traits that may have been present during her son's early or first two years. However, claimant's pediatrician in his early years, and special education professionals in his school years did not find that claimant had autistic-like behaviors of PDD.

65. Dr. Langlois-Dul was the only expert witness in the hearing. She has worked for SARC for eight years, two prior to the end of 1999 and six beginning in 2014. She has performed about 200 evaluations a year for SARC. She has a master's degree in clinical psychiatry and a doctorate in psychiatry. She is a neuropsychologist and has worked in the field of developmental disabilities for 28 years. Her recent and comprehensive evaluation is well-supported and persuasive.

66. Dr. Langlois-Dul thoroughly explained her 2020 evaluation at the hearing. She did not find evidence in the recent application to lead her to reconsider her position from her 2015 evaluation (Finding 41).

67. There is no doubt that claimant has difficulties in adulthood and might benefit from some regional center services. His mother is commended for her persistence and caring to help him become independent.

LEGAL CONCLUSIONS

1. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on the claimant to establish that he or she has a qualifying developmental disability. The standard of proof required is a preponderance of the evidence. (Evid. Code, §§ 115, 500.)

2. A preponderance of the evidence means "the evidence on one side outweighs, preponderates over, or is more than, the evidence on the other side, not necessarily in number of witnesses or quantity, but in its effect on those to whom it is addressed." (*People v. Miller* (1916) 171 Cal. 649, 652.)

3. Under the Lanterman Developmental Disabilities Services Act (Lanterman Act), the State of California accepts responsibility for people with developmental disabilities. (Welf. & Inst. Code, § 4500, et seq.) The purpose of the Lanterman Act is to rectify the problem of inadequate treatment and services, and to enable people with developmental disabilities to lead independent and productive lives in the least restrictive setting possible. (§§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Lanterman Act is a remedial statute; so must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

4. A developmental disability is a disability that originates before an individual reaches age 18; continues, or can be expected to continue, indefinitely; and

constitutes a substantial disability for that individual. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b).) The term "developmental disability" includes intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (a).

5. Conditions that are solely psychiatric in nature, or solely learning or physical disabilities, are not considered developmental disabilities. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

6. The term "substantial disability" is defined as a "condition which results in major impairment of cognitive and/or social functioning" that requires "interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential," and results in significant functional limitations in major life activities for the individual. (Cal. Code Regs., tit. 17, § 54000, subd. (a).)

7. Having "just met the 'Autism' cut-off" in 2005, claimant has not shown he has a "well-established" diagnosis of PDD under DISM-IV, or of Asperger's disorder. Claimant has not met his burden of establishing that he has a developmental disability as that term is defined in the Lanterman Act. Claimant has not shown that he suffers from ASD or intellectual disability.

8. It is undisputed that at present, claimant is substantially disabled. However, it has not been shown that his disabling condition is caused by ASD or by intellectual disability, or by disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals

with an intellectual disability. Regional center services are limited to individuals who meet the statutory eligibility requirements prior to a determination of disability.

9. Individuals with handicapping conditions that are solely physical or psychiatric in nature are not eligible for regional center services under the Lanterman Act. Claimant's impaired functioning appears to be caused by his mental health conditions, hindered by his marijuana use. Comorbidity does not apply since there the criteria for ASD has not been met as one of claimant's diagnoses.

10. Because there is insufficient evidence that claimant has autism spectrum disorder or an intellectual disability, his appeal must be denied.

ORDER

Claimant's appeal of the service agency's denial of regional center eligibility is denied. Claimant is not eligible for regional center services.

DATE:

BARBARA O'HEARN
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.