BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

vs.

ALTA CALIFORNIA REGIONAL CENTER, Service Agency

Agency Case No. CS0012159

OAH No. 2024020369

PROPOSED DECISION

Hearing Officer Coren D. Wong, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference on March 7, 2024, from Sacramento, California.

Claimant's mother and court-appointed conservator (Mother) represented claimant.

Robin Black, Legal Services Manager, represented Alta California Regional Center (ACRC), the service agency.

Evidence was received, and the record was left open to allow claimant to produce additional evidence. Claimant produced: (1) a May 18, 2023 letter explaining

his therapist had initiated the authorization process for an external referral for specialty neuro-diversion informed mental health services; and (2) February 7, 2023 and February 26, 2024 progress notes from his psychiatrist. The additional evidence was included in the record collectively as Exhibit H. At hearing, ACRC waived the opportunity to respond or object to claimant's additional evidence. Exhibit H was admitted for all purposes. The record was closed and the matter submitted for decision on March 14, 2024.

ISSUE

Is ACRC required to increase claimant's Self-Determination Program (SDP) Individual Budget to include funding for behavioral crisis services?

FACTUAL FINDINGS

Background

1. Claimant is a 20-year-young man whom ACRC determined eligible for regional center services on October 27, 2020, based on the developmental disability autism, moderate. His autism causes a substantial disability in self-care, receptive and expressive language, self-direction, and capacity for independent living. ACRC has been providing regional center services since determining claimant eligible.

2. Claimant lives in the family home with his mother and maternal aunt. He has an older sister who lives outside the family home. His parents divorced when he was young, and he has no contact with his father.

3. Claimant likes reading, playing video games, and singing gospel music. He also enjoys going on car rides and walking around the park with his aunt. He can complete activities of daily living with verbal prompting and reminders. He sometimes requires help when using the restroom.

4. Claimant performs chores around the house, including taking out the trash and doing his laundry. He can make small meals or snacks on his own. He uses the toaster oven and microwave but not the oven or stove. Most meals are prepared for him. Mother believes he requires 24-hour supervision and is uncomfortable leaving him unattended.

5. Claimant's generic resources include Supplemental Security Income (SSI), In-Home Support Services through Sacramento County (IHSS), Kaiser Permanente and Capital Star Behavioral Health, and Guardian Life dental insurance. Kaiser Permanente currently pays for Applied Behavioral Analysis (ABA) and specialty neuro-divergent informed mental health services, in addition to claimant's general health care services.

Claimant's Mental Health

DIAGNOSES AND HOSPITALIZATIONS

6. Claimant has a history of mental health struggles. He was diagnosed with attention deficit hyperactivity disorder, combined type, in 2010. He was prescribed Adderall, but Mother did not fill the prescription due to concerns with side effects.

7. Claimant began experiencing delusions about shrinking and God punishing him, which led to a diagnosis of schizophrenia in July 2019. On August 3, 2019, he presented to Sierra Vista Hospital in a psychotic and disorganized state. He complained that bees were flying up and down his throat. He was determined gravely

disabled and involuntarily admitted for psychiatric treatment. His formal diagnosis was psychotic disorder, not otherwise specified. Claimant stabilized enough to be discharged to a lower level of care at one of Kaiser Permanente's crisis residential facilities after 18 days of treatment. The crisis residential facility discharged claimant after three days.

8. Claimant went to Fremont Hospital on August 21, 2019, the day he was discharged from the crisis residential facility. He was experiencing psychotic and delusional thoughts and suicidal ideations about bees being inside his body and God punishing him. He was involuntarily admitted as a danger to himself. He was diagnosed with psychotic disorder, not otherwise specified.

9. Claimant was transferred to Sierra Vista Hospital after two weeks to be closer to the family home. He was discharged September 29, 2019, with a diagnosis of bipolar disorder.

10. Within five hours of discharge, claimant began expressing suicidal ideations about removing the bees inside him. He was brought to San Jose Behavioral Health, where he repeatedly requested an x-ray of his body. He was involuntarily admitted as a danger to himself. He was discharged October 18, 2019, with a diagnosis of delusional disorder, somatic type 2, and possible schizoaffective disorder.

11. Claimant continued treatment on an outpatient basis at Summit View Residential Treatment Center on November 5, 2019. His psychosis worsened during treatment, and he was involuntarily admitted to Sierra Vista Hospital as a danger to himself one week later. Claimant was discharged January 2, 2020, after which he returned to Summit View Residential Treatment Center.

12. Claimant was involuntarily admitted to Sierra Vista Hospital January 20, 2020, after experiencing increased suicidal ideations at Summit View Residential Treatment Center. He remained hospitalized until February 24, 2020. His diagnosis at discharge was chronic paranoid schizophrenia.

13. Claimant's most recent mental health crisis began July 16, 2021. He returned from school showing signs of psychotic and delusional thinking. Mother called Kaiser Permanente's triage nurse and was told to bring him to the emergency room. He was involuntarily admitted as gravely disabled. Claimant transferred to San Jose Behavioral Health after three days. He was discharged August 6, 2021, with a diagnosis of schizoaffective disorder.

14. Claimant returned home. Three days later, he was involuntarily admitted to Sierra Vista Hospital as gravely disabled due to psychosis, including signs of paranoia. He was diagnosed with schizophrenia, paranoid type. Claimant remained hospitalized until October 1, 2021, when he was discharged to continue his recovery at The Jensen Home, an adult residential facility that provided 24-hour nonmedical care and supervision to adults. He was discharged to the family home on May 17, 2022.

TREATMENT

15. In addition to the treatment discussed above, claimant participated in outpatient therapy from 2010 until 2013 due to odd, unusual, and difficult behaviors at home and struggles with peer relationships. He discontinued therapy in February 2013 but returned in October 2015 after receiving a diagnosis of Asperger's syndrome. Therapy focused on disrespectful behavior at home, anger management, appropriate relationships, and peer relationships. The focus of therapy switched around the time claimant was first diagnosed with schizophrenia.

16. Claimant's initial therapists did not specialize in treating patients with autism spectrum disorder (ASD). Approximately one year ago, Kaiser Permanente referred claimant to It Takes The Village for specialty neuro-divergent informed mental health services. Since then, he has been seeing a therapist who specializes in treating patients with ASD on a weekly basis.

17. In addition to therapy, claimant has seen a psychiatrist and been prescribed various psychotropic medications since 2019. He has been with his current psychiatrist since 2022. The following year, the psychiatrist decided to include a pharmacist as part of claimant's treatment team. Claimant alternates each month between seeing his psychiatrist and pharmacist for medication management. His current medications include an antipsychotic (clozapine) and an anticonvulsant (valproate).

CRISIS SERVICES

18. On May 26, 2021, approximately two months before claimant's last mental health crisis, Mother reported to his service coordinator at ACRC that he was exhibiting increased negative behaviors at home, including episodic events of emotional imbalance, distorted thinking, extreme weight loss, and daily vomiting. When Mother asked about his decreased appetite, claimant purportedly explained that not eating shows love. The service coordinator agreed to discuss claimant's behaviors with clinical and behavioral staff for guidance.

19. Based on recommendations from colleagues, claimant's service coordinator gathered information about the Systematic, Therapeutic, Assessment, Resources and Treatment (START) program and sent it to Mother for consideration. The START program provides crisis prevention and response to people ages six years

and above who have intellectual/developmental disabilities and present with complex behavioral and mental health needs. Services include crisis mitigation techniques, therapeutic coaching – in-home support, crisis response, clinical consultation, education and training, and psychoeducation. The program is intended to provide a proactive approach to people who are at-risk and those who support them. It creates a support network to respond to crises at the community level by providing community-based, person-centered supports that enable a person in crisis to remain in their home or community residence.

20. Mother reviewed the information about the START program and told the service coordinator she was interested in receiving services. The service coordinator was in the process of preparing claimant's referral to the START program when she learned about his July 16, 2021 hospitalization. Turning Point Community Programs administers the START program in ACRC's catchment area.

21. On August 4, 2021, Turning Point Community Programs accepted claimant into the START program. In preparation for his discharge from Sierra View Hospital, the START program prepared a Cross-System Crisis Prevention & Intervention Plan (CSCPIP). The CSCPIP outlines general information about claimant such as his demographics, living situation, living environment, medical diagnoses, medications, medical/dental conditions, communication style, strengths/skills/interests, and behavior patterns.

22. The crux of the CSCPIP is an "Intervention Hierarchy," which categorizes different responses to claimant's mental health crisis into one of three different stages based on severity of the crisis. Stage I includes primary interventions that can be provided immediately. Stage II consists of secondary interventions when advice or help is needed from people on-call, specialists, or START coordinators. Finally, Stage III

identifies tertiary interventions available as acute crisis interventions and emergency supports. The CSCPIP includes a chart for each stage, and each column describes claimant's most common signs or symptoms of crisis, personal vulnerabilities, triggers, specific interventions, and people who should be involved in the intervention and their telephone number.

23. Because claimant was discharged from Sierra View Hospital to The Jensen Home rather than to the family home, he was not using the START program services. Therefore, Mother requested that claimant's service coordinator cancel the START program on November 3, 2021, and the service coordinator did so the following day.

24. The mental health services available to claimant through Kaiser Permanente and Capital Start Behavioral Health have been lacking in robustness and limited to addressing his schizophrenia. Mother has continuously advocated for access to services that address his dual-diagnoses of a developmental disability and a mental disability. She discovered the therapy program Helping Each-Other Recognize Our Extraordinary Selves (H.E.R.O.E.S.) that specializes in treating patients with dual-diagnoses, and ACRC funded claimant's participation for a time.

25. Additionally, Mother began utilizing Creating Behavioral & Educational Momentum (CBEM) for crisis services related to training her and other caregivers on how to safely respond to claimant's mental health crises. CBEM provided weekly trainings and offered 24-hour telephone support for five months. It discontinued services in June 2023 after determining claimant no longer needed them.

Provision of Regional Center Services

TRADITIONAL SERVICES DELIVERY MODEL

26. ACRC originally provided claimant regional center services through the traditional services delivery model. A planning team consisting of claimant, Mother, his service coordinator, and The Jensen Home administrator met on November 4, 2021. At the time, claimant was continuing treatment and living in The Jensen Home.

27. Claimant's goals included: (1) receiving a free and appropriate public education; (2) maintaining good physical, mental, and dental health; and (3) residing in a safe home. He was attending Northern California Preparatory School through the Elk Grove Unified School District, and the district was responsible for providing for his educational needs. His service coordinator agreed to support those needs by attending individual education program meetings if invited.

28. Kaiser Permanente was responsible for providing for claimant's physical and mental health needs, and Guardian Life was responsible for his dental needs. The planning team was researching care homes in the community that could provide claimant the level of support he would need upon discharge from The Jensen Home, and ACRC agreed to fund residential services once a suitable location was chosen. ACRC also agreed to fund a Medic Alert bracelet and one year of monitoring.

29. A planning team consisting of claimant, Mother, and his service coordinator reconvened on June 7, 2022. Claimant had recently been discharged from The Jensen Home. He had decided to return home rather than to a residential facility.

30. Claimant's goals were to: (1) live with his Mother and aunt and remain safe in the family home and community; (2) achieve and maintain optimal physical,

mental, and dental health; (3) receive a free and appropriate public education; and (4) reduce and/or eliminate challenging behaviors and increase appropriate replacement skills. His generic resources for physical, mental, and dental health and education remained the same as before. ACRC agreed to fund an Independent Living Skills (ILS) assessment to evaluate his ability to live independently. Additionally, Mother expressed interest in learning how to better respond to and manage claimant's future mental health crises. Therefore, his service coordinator completed a referral to CBEM and for personal attendant (PA) services.

31. A planning team reconvened on January 26, 2023, because claimant decided to change his regional center services delivery method from the traditional services delivery model to SDP. The team prepared an addendum to the June 7, 2022 Individual Program Plan (IPP) memorializing claimant's transition to SDP. The addendum identified a new objective of accessing services through SDP by July 2023. It also provided that claimant and his family must complete the SDP orientation process and identify a financial management services (FMS) provider and service delivery model. They were provided the option of selecting an independent facilitator (IF).

32. A planning team consisting of claimant, Mother, and his two service coordinators (one for the traditional services delivery model, and another for SDP) met for the final time under the traditional services delivery model on October 19, 2023. Claimant's goals were to: (1) continue living in the family home; (2) maintain good physical, mental, and dental health; and (3) continue enhancing his socialization, self-efficacy, community integration, and pre-vocational skills. ACRC agreed to fund respite services, PA, ILS, and music services. ACRC further agreed to fund FMS during claimant's transition to SDP.

SDP

33. Claimant and Mother completed SDP orientation. They selected GT Independence as their FMS provider under the sole-employer model. Jessica Mercado is the person with whom they work. Claimant and Mother also elected to use an (IF) and chose Progressive Employment Concepts. Emily Scholl is their facilitator.

34. Claimant and Mother prepared an SDP Annual Individual Budget. The budget proposed ACRC's continued funding for the following services: (1) in-home respite services; (2) lifeline emergency monitoring (Medic Alert); (3) ILS; (4) PA; and (5) FMS (co-employer model), for a total of $33,524.35. It proposed funding for the following additional services based on claimant's unmet needs and change in circumstances: (1) out-of-home respite services; (2) community integration training (tailored days services (TDS)); (3) sports club (School of Rock Elk Grove); (4) transportation; and (5) transportation companies (transportation to/from TDS), for an additional $84,474.60. Claimant's total proposed SDP Annual Individual Budget was $117,998.95. ACRC certified the budget on January 25, 2024.

35. Claimant and Mother prepared a Spending Plan itemizing on how they intend to allocate the SDP Annual Individual Budget. They allocated funds amongst three budget categories: Living Arrangement ($107,728.96), Employment & Community Participation ($9,500), and Health & Safety ($769.99). Within each category, they identified the following services: (1) Living Arrangement: staff-supported hours for ILS, PA, respite, TDS, etc., to include community-based supports in and out of home, wages include mileage ($107,728.96); (2) Employment & Community Participation: social recreation and activities such as School of Rock Elk Grove and voice and guitar or other community provider ($3,500), and IF services ($6,000); and (3) Health & Safety: Medic Alert ($49.99), crisis intervention supports on hold – if not

covered by ACRC outside of SDP budget (to be determined), and massage therapy ($720). ACRC reviewed and approved the Spending Plan the week after it certified the SDP Annual Individual Budget.

36. A planning team consisting of claimant, Mother, and his two service coordinators met on March 5, 2024, to implement his transition to SDP. The team identified the following goals for claimant: (1) receive regional center services through SDP commencing March 1, 2024; (2) continue living in the family home; (3) maintain good physical, mental, and dental health; and (4) continue enhancing socialization, self-advocacy, community integration, and pre-vocational skills.

37. In addition to ACRC agreeing to fund claimant's SDP Annual Individual Budget so he can purchase the services identified in his Spending Plan, it agreed to fund FMS at a maximum rate of $600 per month and make a one-time payment of $2,500 to Progressive Employment Concepts for person-centered planning and transitional services. Claimant's generic resources remained the same: SSI, IHSS, Kaiser Permanente and Capital Star Behavioral Health, and Guardian Life dental insurance.

Request for Behavioral Crisis Services

38. Mother first raised the issue of reinstating behavioral crisis services for claimant during the transition from the traditional services model to SDP. On December 6, 2023, she sent one of claimant's service coordinators an email requesting four hours of crisis services per month.

39. Nicole Thurner-Glover has been a service coordinator at ACRC for almost three years. Claimant was assigned to her caseload around October 2023. He had already started the process of transitioning to SDP, and Hima Suri was his service coordinator for SDP. Ms. Thurner-Glover explained "crisis services" is a broad category

of different types of services. ACRC's Crisis Services Procedures Manual covers mobile crisis service, client-based service, and residential crisis service. She assumed Mother's December 6, 2023 email was a request for mobile crisis service.

40. According to the procedures manual, mobile crisis service consists of therapeutic intervention and stability services for adults and children with developmental disabilities who need crisis intervention because they are exhibiting behaviors beyond what is typical of alternative behavioral health treatment options in the community. Services may consist of direct intervention, train-the-trainer services, and consultative support with the opportunity to obtain multi-disciplinary supports and costs-agency collaboration. Services are provided on a short-term basis. They are designed to reduce, eliminate, or prevent behaviors that constitute a health and safety risk and increase access to less restrictive services.

41. Ms. Thurner-Glover discussed Mother's request for crisis services with Tricia Cummings, a client services manager at ACRC and Ms. Thurner-Glover's supervisor. They determined the last planning team that met under the traditional services delivery model did not assess claimant as needing crisis services. Therefore, he did not have an assessed need for such services. Ms. Thurner-Glover explained ACRC is prohibited from funding services claimant may hypothetically need in the future.

42. Additionally, ACRC is limited to funding an initial SDP budget in an amount equal to what it spent purchasing services during the 12-month period immediately preceding claimant's transition to SDP, with appropriate adjustments for a change in circumstances or unmet needs. Although ACRC funded CBEM's services for part of that 12-month period – February through June 2023, CBEM determined he no longer needed those services prior to the February 5, 2024 planning team meeting.

Therefore, the planning team considered that to be a change is claimant's circumstances that warranted excluding those funds from his SDP Individual Budget.

Notice of Action and Request for Fair Hearing

43. On January 24, 2024, Ms. Thurner-Glover prepared a Notice of Action (NOA) "denying the request to add funds to [claimant's] Self Determination (SDP) Individual Budget for crisis behavioral services." Five days later, Mother requested a fair hearing challenging the NOA. She explained:

> The client has a history of mental health hospitalizations, break-through symptoms, behaviors, and self-harm risk, therefore a request to the service coordinator was made to add crisis services as a part of the client's SDP spending plan. This service request was denied. It was reported to the client's representative, that there needs to be a crisis or urgent/emergency need occurring before an approval can be made. Once the regional center were to be notified of the crisis/need for services, the service coordinator would be required to go to committee for approval and would be told which agencies would be appropriate to access those services even though it could be weeks before a crisis services provider would become available to the client. This seems unreasonable, given the history of mental health hospitalizations, and because mental health episodes are unpredictable. In 2021, the client had already been hospitalized multiple times for mental health episodes, however, during this period a crisis intervention services

> provider was in place. The client's mother was able to access this service for intervention, support, and safety, which was needed and very helpful. Currently, the client has been diligent in following the prescribed treatment plans by attending regular medical appointments, and participating in rehabilitative programs. Despite these efforts he struggles with random break-through symptoms.

44. At hearing, Mother expressed her concerns that claimant was going to have another psychotic episode soon. She noticed a change in his behavior during the weeks prior to hearing, which in the past has been followed by a psychotic break. Specifically, he has had a decrease in appetite and been less social and less interested in his daily routines, such as listening to music and playing video games.

45. On February 23, 2024, claimant's ABA provider arrived at his home for a regularly scheduled appointment. Mother informed the provider claimant had not been using his computer during the past few days. The provider asked claimant if he wanted Mother to leave the room so he could share how he was feeling or what he was thinking. Claimant was not interesting in having Mother leave and said he was "fine," but Mother interjected and said she would go upstairs.

46. Claimant's ABA provider documented their subsequent conversation as follows:

> [Claimant] then says, "to tell you the truth, I have been having negative thoughts lately. When I see numbers, the numbers can be overwhelming, and the number makes me think about negative things. When I go to YouTube, there is

> a lot of numbers on the website and it gets overwhelming when all of the negative thoughts comes into my head." The [board certified behavior analyst (BCBA)] . . . asked, "I am so sorry that you are [*sic*] negative thoughts that when you are looking at the number. What are the negative things that the number makes you think?" [Claimant], "Well, if you must know, the number makes me think about destruction like burning something, damaging something, using weapons, and other things I don't want to say because it can get really dark." The BCBA . . . asked, "Do you think your medication helps you currently?" [Claimant] stated, "After taking the medication, it doesn't help me and I continue to have negative thoughts and it is hard for me to fight against it every minute." BCBA . . . stated, "I am so sorry, why don't you want to tell your mom about this so that we all can help you through this?" [Claimant] stated, "I'm gonna regret telling her because she's gonna make me take the medication longer."

47. Claimant's ABA provider told Mother about her conversation with claimant. Mother discussed that conversation with claimant's psychiatrist during an appointment three days later. During that appointment, claimant agreed he was experiencing unpleasant intrusive thoughts. However, he denied any thoughts of self-harm or harming others, as well as auditory and visual hallucinations and paranoia.

48. Claimant's psychiatrist documented his updated risk assessment of claimant as follows:

Suicidal Ideation: Denied

Homicidal Ideation: Denied homicidal ideation

Denies access to firearms

Suicide Risk Assessment: Chronic elevated risk for suicide based upon age, gender, [history] psychosis, [history] poor impulse control with adhd. Acute risk is low as he does not report passive or active suicidal ideation. He likewise does not report thoughts of self-harm or injury. Does not appear intoxicated. No active substance use. Euthymic mood. Denies depression and denies passive [suicidal ideation] and active [suicidal ideation]. Denies plan to end his life. No positive psychotic symptoms observed. Protective factors include future orientation, engagement in treatment and sense of responsibility to family. Does not meet criteria for 5150 [danger to self].

Violence Risk Assessment: Low risk. No active substance use. No personality pathology. No history of violence. No current aggressive, violent, psychotic, or manic symptoms. Does not meet criteria for 5150 [danger to others].

49. Claimant's psychiatrist concluded:

Patient presenting with slightly worsening symptoms in the context of psychosocial stressors as noted above. Patient is at low risk for danger to self or others, has hope, is forward

thinking, reports strong reasons to live. Patient is at low risk for danger to self or others, based on review risk factors and protective factors as noted above.

50. Mother also explained at hearing that claimant still has access to mental health services through Kaiser Permanente and Capital Star Behavioral Health, but services are available only Monday through Friday during normal business hours, except in emergency situations. She recognizes that a mental health crisis constitutes an emergency, but her goal is to keep claimant out of the emergency room and out of the mental hospital. Therefore, she believes having behavioral crisis services available would be beneficial. And because a crisis can occur suddenly and without warning, it is unreasonable to require her to wait to request services until claimant is in the midst of a crisis.

51. Ms. Cummings explained ACRC cannot fund services "just in case." Claimant must have an assessed need requiring any services ACRC funds. Not only did the October 19, 2023 planning team not assess claimant as needing behavioral crisis services, but the February 5, 2024 team did not either.

52. Ms. Cummings further explained claimant is not without support. He is free to reallocate funds in his SDP Individual Budget to behavioral crisis services, even though no such services are identified in his Spending Plan. Additionally, he has mental health services available through Kaiser Permanente and Capital Star Behavioral Health, including emergency services. Finally, claimant can renew his request for services through ACRC if he does suffer a mental health crisis.

Analysis

53. Claimant has the burden of proving by a preponderance of the evidence that ACRC is required to increase his SDP Individual Budget to include funds for behavioral crisis services. ACRC may fund only those services for which claimant has an assessed need. And though SDP provides greater freedom in how he receives those services, ACRC cannot fund services through SDP that it would not have funded through the traditional services delivery model.

54. Respondent has no assessed need for behavioral crisis services. Neither of his last two planning teams assessed him as needing those services. Significantly, he saw his psychiatrist on February 26, 2024. His psychiatrist concluded claimant had only "slightly worsened symptoms in the context of psychosocial stressors" and was "at low risk for danger to self or others."

55. Furthermore, claimant attends weekly therapy with a therapist who specializes in treating clients with ASD. His therapist did not testify at hearing. Nor did he write a letter in support of claimant's need for behavioral crisis services.

56. Claimant was not receiving behavioral crisis services immediately prior to his transition to SDP. ACRC is prohibited from including money in the SDP Individual Budget to purchases services it would not have provided under the traditional services delivery model.

57. Lastly, claimant is required to exhaust generic resources prior to ACRC funding services under either delivery model. He has access to mental health services through Kaiser Permanente and Capital Star Behavioral Health. He must access those services prior to relying on ACRC funding. The preponderance of the evidence does

not establish ACRC is required to increase claimant's SDP Individual Budget to include funds for behavioral crisis services.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Claimant has the burden of proving ACRC is required to increase his SDP budget to include funding for behavioral crisis services. (*In re Conservatorship of Hume* (2006) 140 Cal.App.4th 1385, 1388 [the law has "a built-in bias in favor of the status quo," and the party asking a court to do something has the burden "to present evidence sufficient to overcome the state of affairs that would exist if the court did nothing"].) The applicable standard of proof is preponderance of the evidence. (Evid. Code, § 115.) This evidentiary standard requires claimant to produce evidence of such weight that, when balanced against evidence to the contrary, is more persuasive. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.) In other words, he must prove it is more likely than not he is entitled to funding in his SDP budget to purchase crisis services. (*Lillian F. v. Super. Ct.* (1984) 160 Cal.App.3d 314, 320.)

Applicable Law

2. In establishing the SDP, the Department of Developmental Services (Department) is required to address the following:

> (A) Oversight of expenditure of self-determined funds in the achievement of participant outcomes over time.

(B) Increased participant control over which services and supports best meet the participant's needs and the IPP objectives. A participant's unique support system may include the purchase of existing service offerings from service providers or local businesses, hiring their own support workers, or negotiating unique service arrangements with local community resources.

(C) Comprehensive person-centered planning, including an individual budget and services that are outcome based.

(D) Consumer and family training to ensure understanding of the principles of self-determination, the planning process, and the management of budgets, services, and staff.

[¶] . . . [¶]

(G) Innovation that will more effectively allow participants to achieve their goals.

(H) Long-term sustainability of the Self-Determination Program by doing all of the following:

(i) Requiring IPP teams, when developing the individual budget, to determine the services, supports and goods necessary for each consumer based on the needs and preferences of the consumer, and when appropriate the consumer's family, and the effectiveness of each option in

> meeting the goals specified in the IPP, and the cost effectiveness of each option, as specified in subparagraph (D) of paragraph (6) of subdivision (a) of Section 4648.
>
> (ii) The department may review final individual budgets that are at or above a spending threshold determined by the department of all individual budgets and use information from its review in the aggregate to develop additional program guidance and verify compliance with federal and state laws and other requirements.

(Welf. & Inst. Code, § 4685.8, subd. (b)(2).)

3. A consumer's SDP individual budget is the amount of regional center funding provided "for the purchase of services and supports necessary to implement [his] IPP." (Welf. & Inst. Code, § 4685.8, subd. (c)(3).) SDP is "a voluntary delivery system consisting of a defined and comprehensive mix of services and supports, selected and directed by a participant through person-centered planning, in order to meet the objectives in their IPP." (*Id.*, subd. (c)(6).) A consumer's spending plan is his plan on how to allocate his SDP individual budget "to purchase goods, services, and supports necessary to implement [his IPP]." (*Id.*, subd. (c)(7).)

4. A consumer may use funds from his SDP individual budget to purchases services and support "only when generic services and supports are not available." (Welf. & Inst. Code, § 4685.8, subds. (d)(3)(B) & (r)(6).) Additionally, "only . . . [those] services and supports necessary to implement [his] IPP" may be purchased. (*Id.*, subd. (d)(3)(C).)

5. The initial SDP individual budget for a regional center consumer who switches from the traditional services delivery model "shall be the total amount of the most recently available 12 months of purchase of service expenditures for the participant." (Welf. & Inst. Code, § 4685.8, subd. (m)(1)(A)(i).) That amount may be increased or decreased if: (1) the planning team determines an adjustment is necessary due to a change in the consumer's circumstances or an unmet need; and (2) the regional center certifies that the total amount of expenditures, including any adjustment, would have occurred if the consumer remained under the traditional services delivery model. (*Id.*, subd. (m)(1)(A)(ii)(I), (II).)

Conclusion

6. Claimant did not meet his burden of proving ACRC is required to increase his SDP Individual Budget to include funds for behavioral crisis services. Therefore, his appeal should be denied.

ORDER

Claimant's appeal from Alta California Regional Center's January 24, 2024 Notice of Action denying his request to add funds to his SDP individual budget for behavioral crisis services is DENIED.

DATE: March 25, 2024

COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

Claimant

OAH Case No. 2024020369

Vs.

DECISION BY THE DIRECTOR

Alta California Regional Center (ACRC),

Respondent.

ORDER OF DECISION

On March 25, 2024, an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH) issued a Proposed Decision in this matter.

The Department of Developmental Services (DDS) takes the following action on the attached Proposed Decision of the ALJ:

The Proposed Decision is adopted by DDS as its Decision in this matter. The Order of Decision, together with the Proposed Decision, constitute the Decision in this matter.

This is the final administrative Decision. Each party is bound by this Decision. Either party may request a reconsideration pursuant to Welfare and Institutions Code section 4713, subdivision (b), within 15 days of receiving the Decision or appeal the Decision to a court of competent jurisdiction within 180 days of receiving the final Decision.

Attached is a fact sheet with information about what to do and expect after you receive this decision, and where to get help.

IT IS SO ORDERED on this day April 17, 2024.

Original signed by:

Nancy Bargmann, Director