BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

SAN ANDREAS REGIONAL CENTER, Service Agency.

DDS. No. CS0020801

OAH No. 2024090935

DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, who served as the hearing officer, heard this matter on January 28, March 18-19, April 7-9, May 1, and May 13-15, 2025, by videoconference.

Claimant was represented by his parents. Claimant was not present at the hearing.

James Elliott, Executive Director's Designee, represented San Andreas Regional Center (SARC).

The record remained open for the submission of closing written arguments, and for claimant to submit a rebuttal. These submissions were timely received and marked as Exhibit 21 (SARC), Exhibit C-83 (Claimant), and Exhibit C-84 (Claimant's rebuttal).

The record closed and the matter was submitted for decision on June 13, 2025.

ISSUE

Is claimant eligible for regional center services?

FACTUAL FINDINGS

Background

1. Claimant is 11 years old. Claimant has been diagnosed with autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), major depressive disorder (MDD), and disruptive mood dysregulation disorder (DMDD). Claimant has also been diagnosed with a neuromuscular condition. Claimant is currently residing at a residential treatment center in northern California.

2. Claimant's family sought regional center services in 2023. SARC staff conducted an intake social assessment of claimant, obtained documents from his family, and a SARC psychologist met with claimant for an assessment on May 7, 2024.

3. Based on a report authored by SARC's psychologist, the eligibility team determined that claimant did not satisfy eligibility criteria. SARC notified the family

that claimant was ineligible for services, and the family appealed SARC's determination.

Regional Center Eligibility Criteria

4. To be eligible for services under the Lanterman Developmental Disabilities Services Act (Lanterman Act, Welf. & Inst. Code, § 4500 et seq.), an individual must have a developmental disability that originates prior to age 18; the disability must not be solely physical in nature; the disability must be expected to continue indefinitely; and the disability must constitute a substantial disability for the individual. (Welf. & Inst. Code, § 4512, subd. (a)(1).) A substantial disability is defined as the existence of significant functional limitations in at least three of the following major life activity areas, as appropriate to the age of the individual: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (*Id.*, subd. (*l*)(1).)

Economic self-sufficiency is not taken into consideration when evaluating a child claimant's age, because children of this age are not typically expected to be economically self-sufficient.

5. Claimant contends that he has a developmental disability (ASD) and significant functional limitations in all six relevant domains. SARC disputes the ASD diagnosis and contends that claimant is not substantially disabled in three or more areas of major life activity.

Diagnostic Criteria for ASD

6. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM 5-TR), published by the American Psychiatric Association, sets forth the diagnostic criteria for ASD:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of 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 contact; 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 interest).

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 of objects, visual fascination with lights for 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 development disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, social communication should be below that expected for general developmental level.

7. The DSM 5-TR contains guidance for clinicians to designate a severity level for social communication and for restricted, repetitive behaviors. Level 3 means the individual requires very substantial support, Level 2 means the individual requires substantial support, and Level 1 means the individual requires support.

8. Although not mandated by law, individuals with Level 1 severity ASD are usually not found eligible for regional center services under the Lanterman Act.

School Assessments and Special Education Services

9. Claimant has received special education services since he was in transitional kindergarten in 2018. The original assessment in 2018 noted issues with impulsivity, social skills, and emotional regulation. Although he displayed some traits

consistent with ASD, he was found eligible for services under the categories Other Health Impairment and Speech or Language Impairment. He was provided with a 1:1 aide and placed in the school district's comprehensive autism program, despite not having an ASD diagnosis at the time and having not been classified as eligible for special education services based on autism.

10. The following school year, claimant attended kindergarten in a general education classroom with a 1:1 aide and significant other supports. In-person school was shut down in March 2020 due to the pandemic.

11. When full-time, in-person school resumed in Fall 2021, claimant was in the second grade. Claimant was reassessed and continued to be found eligible for special education services under the Other Health Impairment and Speech or Language Impairment categories. The services provided included 1,630 minutes per week of intensive individual service.

12. The family moved to another school district for the 2022-2023 school year and claimant started third grade in a new school. He was placed in a general education class with a 1:1 aide. Claimant received counseling at school from a licensed psychologist. This psychologist shared with claimant's parents her suspicion that claimant has ASD.

13. In March 2023, a psychoeducational assessment and an educationally related mental health services assessment were performed to determine whether claimant qualified for special education services under the autism or emotional disturbance categories. The evaluator concluded that claimant did not qualify under autism but did qualify under emotional disturbance. She noted claimant's aggression

and atypical behaviors including urinating and defecating on the school restroom floors.

14. Claimant was hospitalized as a danger to himself and others several times from March through July 2023. He reported having been bullied at school and not consistently receiving the special education services in his Individualized Education Program (IEP), including the 1:1 aide.

15. For most of the 2023-2024 school year, claimant lived in a residential treatment center in San Diego, the San Diego Center for Children (SDCC), and attended school there. He was first diagnosed with ASD during this time by SDCC psychologists. Claimant returned home in April 2024 and received home hospital instruction. He was again hospitalized several times in July and August 2024.

16. Since September 2024, claimant has been living in a residential treatment facility located in northern California and attending an affiliated non-public school. The school district believes that this placement is the least restrictive environment for claimant to be able to access education. Claimant is currently the only student in his school district at a residential treatment center. The facility is a two-hour drive from claimant's parents' home. At the facility, staff members are required to keep claimant within their line of sight at all times.

17. Applicant's most recent IEP from December 2024 now classifies him as eligible for special education services under autism as the primary category, with emotional disturbance as the secondary category. Psychoeducational testing in 2024 included administration of the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), with claimant's overall score meeting the cut-off for ASD.

SARC Eligibility Determination

18. Claimant's family approached SARC for an eligibility determination in October 2023. Claimant's family provided documents to SARC. Claimant and his parents attended an intake social assessment interview on March 26, 2024. SARC's Psychologist Cristal Byrne, Ph.D., and Intake Service Coordinator Antonia Mendoza attended the assessment. Due to the family's concerns about claimant's behavior and concerns that he would become upset listening to the discussions about him, claimant and his father left the interview room after about 20 minutes. Claimant's father sat with claimant and allowed him to play a video game.

19. Because she had only limited time with claimant during the intake meeting, Dr. Byrne invited claimant to return for a one-on-one assessment, which took place on May 7, 2024. Dr. Byrne interviewed claimant and administered part of the ADOS-2. She offered claimant short breaks to check in with his mother in the lobby. When Dr. Byrne returned to bring claimant back to finish her assessment after the second break, claimant was yelling and hitting his mother. Dr. Byrne told claimant's mother to step away while Dr. Byrne tried to calm him. Claimant wanted to find his mother and started looking for her in the building. Dr. Byrne followed claimant downstairs and blocked the door to prevent him from leaving the building. Claimant was starting to calm down. Claimant said to Dr. Byrne, "I'm sorry I'm going to hurt you" and shoved her. Dr. Byrne did not finish the evaluation for her safety. She believed that she had sufficient information to reach a determination regarding Lanterman Act eligibility and did not schedule an additional session with claimant.

20. Dr. Byrne wrote a report detailing her conclusion that claimant does not have ASD and does not meet Lanterman Act eligibility requirements. Dr. Byrne testified at hearing to explain her role at SARC and the decision to deny eligibility. Dr. Byrne

received her Ph.D. in human development and psychology in 2016. She has been a staff psychologist for SARC for about two years. She has approximately five years of experience diagnosing individuals for ASD and working with individuals with ASD. She has received specialized training in evaluating individuals for regional center eligibility. Her role in the eligibility process is not to diagnose individuals, but to verify whether the individual has an eligible condition.

21. Dr. Byrne does not believe that claimant meets the diagnostic criteria for ASD. She did not observe any of the requisite deficits in social communication and did not observe any restricted interests or repetitive behaviors during her time with claimant. She also noted a lack of evidence of ASD traits during the early developmental period. During her meeting with claimant, Dr. Byrne observed behaviors which she described as inconsistent with an ASD diagnosis, such as good eye contact and good use of verbal and nonverbal communication. Claimant initiated conversation and provided information unprompted. It took him a little while to warm up, but he became comfortable and acted appropriately. She explained that an individual with ASD cannot be coaxed into appropriate social interactions.

22. Dr. Byrne believed that she had a good body of records to review to assess claimant's eligibility. She reviewed reports from early age and did not see a history of deficits in social reciprocity. She believes that claimant's problems with social reciprocity occur only when claimant is dysregulated and not across all environments, weighing against a finding of ASD.

23. Dr. Byrne described the ADOS as the "gold standard" of diagnostic tools for ASD. It typically takes 30 to 60 minutes to administer. Dr. Byrne described it as a sensitive tool that liberally identifies ASD behaviors, including behaviors in individuals without ASD who suffer from other conditions such as untreated depression. She was

unable to score the ADOS-2 that she administered to claimant because it was unfinished, but got useful information from the portion that was completed.

24. Dr. Byrne believes that claimant's deficits are better explained by the other diagnoses which have been given him. There are overlapping symptoms between ASD and ADHD and it can sometimes be difficult to distinguish between ASD and ADHD. Children with ADHD can struggle with socialization, sensory input, executive functioning, and emotional and behavioral regulation. Dr. Byrne saw no symptoms in claimant that could not be explained by ADHD or another one of his diagnoses.

25. Dr. Byrne highlighted some of claimant's records which she relied on in her determination that claimant does not have ASD.

a. A school psychologist prepared a School Psychological Report in December 2018, when claimant was five years old. The school psychologist concluded that claimant's behaviors were attention seeking. The related 2018 IEP reflects that claimant was not receiving special education services under the autism category. The primary category, other health impairment, is common for children with ADHD. School records reflected that claimant's language developed normally; children with ASD usually have delays in language development. Impulsivity and willful behavior documented in the records are consistent with ADHD.

b. Testing noted in the 2021 IEP showed average to advanced academic achievement on the Woodcock-Johnson assessment, 4th Edition. Autism Spectrum Rating Scales (6–18 Years) (ASRS) were completed by claimant's mother and teacher, with the teacher's responses mostly in the "average" category. Elevated scores in self-regulation and attention are consistent with ADHD. The difference between teacher

and parent scores suggests that the behaviors are not pervasive. The school psychologist in 2021 concluded that claimant's behaviors related to ADHD.

c. Dr. Byrne relied heavily on the 2023 report of Heidi Wheeler, Ph.D., at the Child Mind Institute, which she described as thorough. Dr. Wheeler reported claimant scored well below the cutoff score for ASD on the ADOS-2. Other testing did not suggest substantial impairment in communication, self-care, adaptive functioning. Dr. Byrne's review of Dr. Wheeler's narrative report of her observations also suggested ADHD and not ASD. Dr. Wheeler endorsed claimant's prior diagnosis of ADHD and found that he met the criteria for DMDD. Dr. Wheeler wrote that claimant "does not meet criteria for a social developmental disorder at this time. However, given the duration and severity of [claimant's]social struggles at school and home, his social development should continue to be monitored and re-evaluated for signs of a social developmental disorder."

d. Dr. Byrne found the ASD diagnosis by SDCC unpersuasive. She noted that the ADOS-2 was not used.

26. The eligibility team did not consult with a physician because they did not believe it to be necessary in this case. A physician is not typically consulted in eligibility cases involving ASD.

27. Dr. Byrne further concluded that applicant does not have significant functional limitations in three domains, as required to establish substantial disability for Lanterman Act eligibility. In evaluating significant functional limitations, SARC considers the individual's capacity to perform the activity, not their willingness or consistency in performing the activity. An individual who performs the activity in one

environment but not in other environments would not be considered to be substantially disabled in that domain.

a. Mobility limitations are not associated with ASD. Dr. Byrne observed claimant walking and using the stairs and saw nothing unusual. Claimant is able to ambulate without assistive devices. To the extent that he has any limitations with his mobility, these are due to his neuromuscular condition.

b. Dr. Byrne did not observe functional limitations in expressive or receptive language. She reported that claimant understood her and she understood him. His answers to her questions were appropriate and responsive. She noted that individuals with ASD can struggle with social pragmatics, but that children with other conditions, including ADHD, PTSD, and social anxiety, can as well.

c. For self-care, SARC looks at whether an individual has the ability to do tasks such as hygiene, grooming, and eating independently, not whether the individual consistently performs these tasks. The inability must be pervasive to constitute limitations due to a developmental disability. Parents reported at the intake meeting that claimant was able to dress himself, complete basic hygiene tasks, drink from an open cup, and eat with a spoon and fork. Some difficulties with fine motor skills caused by his neuromuscular condition were reported. She determined that claimant does not have significant functional limitations in self-care.

d. For capacity for independent living, SARC looks at the individual's development in this area compared to same-age peers. Parents reported that claimant could perform simple chores, prepare simple meals such as a sandwich, use the toaster or microwave, and use the phone to make a phone call. Dr. Byrne concluded that

claimant does not have significant functional limitations in his capacity for independent living.

e. In assessing claimant's capacity for learning, Dr. Byrne reviewed his school records and looked at his academic achievement and cognitive testing. An individual with some weaknesses or inconsistencies in learning would not be considered to have substantial impairment in learning. An individual with poor academic achievement compared to their capacity would also not be considered substantially impaired. She noted that claimant's full-scale IQ is within the average range and concluded that any struggles with learning relate to claimant's behavior and not to a developmental disability. She concluded that claimant does not have significant functional limitations in learning.

f. Dr. Byrne explained that impairment in self-direction does not prove an individual has ASD. Impairment in self-direction can be caused by ADHD or PTSD. Dr. Byrne found that claimant does have significant functional limitations in self-direction, noting his history of destructive, self-injurious, and aggressive behaviors which have necessitated hospitalizations and placement in a residential treatment center. However, she concluded that these behaviors are best accounted for by one of his mental health conditions, and not due to a Lanterman Act eligible condition.

Claimant's Evidence

28. Claimant's parents testified credibly regarding claimant's significant challenges and their struggles supporting him. They reported that he cried constantly as a baby and was highly sensitive to sensory stimuli. His social struggles became apparent to them at age two when he began preschool. Claimant's parents continued to believe that he would "outgrow" his behaviors.

29. Claimant's parents had misconceptions about ASD which they believe contributed to claimant not receiving an ASD diagnosis earlier. They did not seek a full evaluation until he was nine years old. They acknowledge that claimant also suffers from mental health conditions. They believe the comorbid conditions complicated the diagnosis of ASD. The ASD diagnosis has helped them better understand and interact with claimant.

30. Claimant's parents want claimant to return to their home. They explained that claimant has gained weight and developed fatty liver disease since living in a residential treatment facility, which they attribute to an unhealthy diet.

31. Claimant has been aggressive towards his family, including his younger brother and sister, and has engaged in self-harm. He has damaged property, stolen money, and called 911 many times for no reason. He cannot manage his hygiene without prompts and oversight. He does not wipe himself after defecating. He defecates in his room, and urinates in his bed or in the car, and has told his mother it is because he does not want to sit on a toilet seat that has germs on it from someone else and does not like the sound of the toilet flushing. He will overeat or eat inedible things if unsupervised. If unsupervised, he will not wear underwear and will put his clothes on backwards. He refuses to engage in physical therapy and refuses to take his medications.

32. Claimant's behaviors escalated in 2023. He was hospitalized numerous times before spending nine months at the SDCC, from July 2023 through April 2024. During this time, one parent flew or drove to San Diego almost every week to visit him. Claimant's parents continue to visit him regularly at the treatment center where he is currently placed.

33. Claimant started ABA therapy in June 2024.

34. In August 2024, claimant's psychiatrist reported to child protective services that claimant had harmed his younger brother. Claimant was placed in a crisis stabilization unit.

35. In September 2024, claimant was agitated and aggressive in a public library. He was with a therapist. He hit the therapist and eloped. In late September, claimant's parents agreed to send him to his current residential placement. He continues to engage in disruptive and noncompliant behavior at the facility and when he is with his parents.

SAN DIEGO CENTER FOR CHILDREN ASD DIAGNOSIS

36. Claimant was first diagnosed with ASD at the SDCC in 2023. Anna Whitehouse, Ph.D., a post-doctoral fellow, performed the evaluation under the supervision of licensed psychologist Cindy Barreda Schurr, Psy.D. Claimant was nine years old at the time. Claimant was observed in class and in his residential unit. Dr. Whitehouse interviewed claimant's parents and reviewed documents including prior assessments and school records. She assessed claimant using the Childhood Autism Rating Scale, Second Edition (CARS-2), based on her direct observations and interviews with claimant's mother, teacher, and residential staff. The resulting score demonstrated mild to moderate symptoms of ASD. Dr. Whitehouse's primary diagnosis was ASD, without intellectual or language impairment, severity Level 1 in both social communication and restricted interests/repetitive behaviors. She wrote that the behavior that she observed was also consistent with PTSD, ADHD, and DMDD. She noted the high prevalence of comorbidity between ASD and other disorders, especially DMDD. She noted that claimant had a "complex neurodevelopmental, social,

emotional, and behavioral presentation." She recommended that claimant's family seek regional center services.

BRENDAN PRATT, PH.D.

37. Psychologist Brendan Pratt, Ph.D., conducted an evaluation of claimant during the summer of 2024. Dr. Pratt is the Chief Executive Officer of the Pratt Institute in Saratoga. He has been licensed by the Board of Psychology since 2002. He reviewed thousands of pages of documents and interviewed and administered assessments to claimant on eight separate days. He wrote a report and testified at the hearing.

38. Dr. Pratt concluded that claimant meets the diagnostic criteria for ASD, Level 1; ADHD; MDD, Severe, Single Episode; and DMDD. He did not endorse a PTSD diagnosis at the time of his evaluation.

39. From his review, Dr. Pratt concluded that there was sufficient evidence to support an ASD diagnosis by the time claimant was five years old. He noted that although claimant was not receiving special education services under the special education classification of autism, he was receiving the type of services that would be provided to a child with ASD, such as participation in the comprehensive autism program and a 1:1 aide. These services would not typically be provided to a child whose deficits are due only to ADHD.

40. Dr. Pratt believes that ASD and ADHD are claimant's most pervasive conditions, with ASD responsible for most of his ongoing challenges. Claimant's depression is a complicating factor.

41. Dr. Pratt believes that claimant has significant functional limitations in self-care due to ASD. For example, claimant's rigid thinking, characteristic of ASD,

causes him to choose maladaptive solutions to problems, such as defecating and urinating in inappropriate places to avoid using a bathroom shared by others. Claimant also resists wearing underwear and does not wipe himself clean after defecating. He needs supervision for self-care and frequent reminders.

42. Dr. Pratt described claimant as having issues with pragmatic language facial expressions, and interrupting others, but reported that his overall language skills are good. His issues arise where language overlaps with social demands.

43. Dr. Pratt reported that claimant's intellectual and academic functioning are not impaired. He endorses claimant's placement at a residential treatment center. He does not believe that claimant has significant functional limitations in learning.

44. Dr. Pratt believes that claimant's ASD-related rigidity makes it harder for him to progress and follow plans, and that this impairs his mobility.

45. Dr. Pratt believes that claimant has significant functional limitations in self-direction due to ASD. He does not believe that claimant's limitations can be attributed solely to his mental health diagnoses.

46. Dr. Pratt believes claimant has significant functional limitations in his capacity for independent living. He noted that typically developing 11-year-old children would be beginning to independently access the community, such as by walking or biking to a friend's house. He believes claimant cannot independently engage in these tasks and is not safe in the community unsupervised. He also noted that claimant does not dress appropriately or eat appropriately, and needs extra supervision in the kitchen.

47. Dr. Pratt does not believe that claimant's history of disruptive behavior, attention-seeking, and revenge-motivated behavior is inconsistent with ASD.

HEIDI WHEELER, PH.D.

48. Dr. Wheeler assessed claimant in 2023 and updated her evaluation in 2025. As discussed above, Dr. Byrne relied heavily on Dr. Wheeler's 2023 evaluation report in reaching her conclusion that claimant is not developmentally disabled.

49. Dr. Wheeler spent 12 hours with claimant over five sessions in 2023. Claimant needed to be placed in a crisis stabilization unit and she was not able to complete her assessment.

50. Dr. Wheeler did not have enough evidence to support an ASD diagnosis in 2023 by the time her testing ended due to claimant's crisis. She testified that she could not support an ASD diagnosis at that time but could not rule it out, either.

51. Dr. Wheeler was surprised to read Dr. Byrne's report stating that Dr. Wheeler had ruled out ASD in 2023. Dr. Byrne did not contact Dr. Wheeler to discuss her report.

52. Claimant's parents requested that Dr. Wheeler update her evaluation. In February 2025, Dr. Wheeler reviewed additional documents, including the SDCC evaluation, SARC's eligibility determination letter, medical records, Dr. Pratt's report, and school records post-dating her previous report. She did not perform any additional testing. She administered the Autism Diagnostic Interview – Revised (ADI-R) to claimant's parents. She found them to be trustworthy. She also interviewed a prior teacher and staff members at the residential treatment facility.

53. Dr. Wheeler conducted a behavioral observation of claimant at the residential treatment facility on February 18, 2025, for about one hour. She spoke with staff at the center, and was told that claimant was having "an unusually good day" on the day of her visit. Dr. Wheeler observed inflexibility and unusual behaviors suggestive of ASD, even when claimant was well-regulated. She was shocked to see his mobility had deteriorated and he had developed a "shuffling" gait.

54. Dr. Wheeler concluded that claimant meets the criteria for ASD, without intellectual or language impairment. She assessed the severity of his deficits in social communication at Level 1 and in restrictive and repetitive behavior at Level 2. She explained that she observed consistently poor adaptive functioning over time and that claimant is not developing as would be typical. ASD can present in subtle ways in some individuals and might not be diagnosed until later in life. Dr. Wheeler opined that ASD and ADHD are claimant's primary diagnoses.

55. Dr. Wheeler explained that individuals with ASD can retaliate against others or be motivated by revenge due to a rigid sense of justice.

56. Dr. Wheeler believes that claimant is substantially disabled in self-care, language, learning, self-direction, mobility, and his capacity for independent living.

57. Dr. Wheeler noted that ASD can impact motor planning and behavior. This is a factor in claimant's refusal to be physically active and eat a healthy diet, and contributes to his impairment in mobility.

58. Dr. Wheeler noted that claimant has unhygienic behaviors such as urinating and defecating in his room, not wiping himself after defecating, and not wearing underwear. Claimant is not caring for himself as she would expect of a child his age.

59. Dr. Wheeler explained that claimant's underdeveloped pragmatic language skills impair his ability to adapt to different contexts and to make friends.

60. Dr. Wheeler believes that claimant's significant deficits in self-direction are the result of ASD and ADHD and impact all aspects of his life.

61. Dr. Wheeler believes that claimant is substantially impaired in learning, noting that he has not been able to stay regulated in a general education class, even with a 1:1 aide, and is still struggling at his residential treatment center. He wears headphones due to his sensory sensitivity, which can interfere with his ability to hear in school.

62. Dr. Wheeler believes that claimant has significant functional limitations in his capacity for independent living. He needs constant adult supervision. The residential treatment center does not allow him in the kitchen, in part because he hides food and eats forbidden food.

OTHER MEDICAL PROVIDERS

63. Claimant's pediatrician, Jane S. Auh, M.D., wrote that she has been claimant's physician since June 2022 and that every time she has seen him, he has demonstrated inconsistent eye contact, lack of social appropriateness, and an inability to have age-appropriate reciprocal conversation. She believes his behaviors are consistent with autism, and that his other diagnoses do not explain his symptoms and behavior.

64. Claimant has been under the care of psychiatrist Karthik Ramgopal, D.O., since April 2024. Dr. Ramgopal wrote a letter dated July 30, 2024, in support of regional center eligibility. Dr. Ramgopal believes that claimant has ASD, and wrote that

he has observed deficits in social communication and restricted/fixed interests. He agrees that claimant suffers from psychiatric conditions, but also believes that neurodevelopmental symptoms are present.

65. Psychiatric Mental Health Nurse Practitioner Priscilla Bui works with Dr. Ramgopal and has been treating claimant in person and through telehealth appointments since August 2024. She has observed claimant displaying symptoms of ASD. She believes that ASD is substantially impacting his ability to engage in academic and community settings.

66. Cara Piccoli, M.D., has been treating claimant for polyneuropathy of uncertain etiology at Stanford Children's Health neuromuscular clinic since 2022. She wrote two letters and testified at the hearing. In her clinic, she has seen evidence of poor motor planning, dyspraxia, emotional dysregulation, and restrictive behaviors, which she believes are consistent with ASD.

Dr. Piccoli believes that claimant's profound functional limitations cannot be solely explained by his medical condition and believes that behavior is impacting his mobility. Because she is not an expert in this area, she cannot distinguish which of his conditions are causing these behavioral impacts. Claimant's functioning has been rapidly declining, and Dr. Piccoli believes that he has significant functional limitations in mobility. She is hopeful that with time and effort, claimant will achieve gains in his functioning.

SPEECH AND LANGUAGE

67. Claimant is receiving speech and language therapy remotely pursuant to his IEP. In-person testing was performed in December 2024. Claimant's speech therapist testified that he requires adult supervision in the room with him when she

conducts remote therapy sessions and assessments. She reported that claimant has a formal way of speaking and uses formal vocabulary atypical of his age. She reported that claimant has significant challenges understanding and using nonverbal communication. He has difficulty applying skills that he demonstrates in testing in real-life situations. His pragmatic language deficits make it difficult for him to interact with peers.

SCHOOL DISTRICT DIRECTOR OF SPECIAL EDUCATION

68. The director of special education for claimant's school district testified that the district explored many alternatives before determining that claimant required a residential placement for his safety. It was difficult to find a placement for claimant because very few residential facilities in California will accept a child his age, with many only serving children 14 years and older. He is the only child in the district in a residential placement. Claimant's ASD diagnosis was a factor in the search for an appropriate factor because it impacts his ability to learn. The district views this placement as the least restrictive means for claimant to access education. The director described claimant as "the most intense case" she has seen.

69. Claimant's residential treatment center recently requested and was authorized to provide additional hours of supervision to claimant. The facility removed the carpet and made other changes to his room to maintain cleanliness in light of claimant's behavior of urinating and defecating in his room. He continues to struggle at school, including difficulty with transitions, aggression, emotional dysregulation, impulsivity, and elopement attempts.

LEGAL CONCLUSIONS

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

2. A developmental disability is a disability that originates before an individual attains age 18, is likely to continue indefinitely, and constitutes a substantial disability for that individual. (Cal. Code Regs., tit. 17, § 54000, subd. (b).) The term "developmental disability" includes intellectual disability, autism, epilepsy, cerebral palsy, and what is referred to as the "fifth category." (Welf. & Inst. Code, § 4512, subd. (a).) The fifth category refers to "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Id.*)

3. Pursuant to Welfare and Institutions Code section 4512, subdivision (*l*), the term "substantial disability" is defined as "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: (1) Self-care. (2) Receptive and expressive language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living. (7) Economic self-sufficiency."

4. It is claimant's burden to prove that he has a developmental disability, as that term is defined in the Lanterman Act. The standard of proof is a preponderance of the evidence.

5. A preponderance of the evidence established that claimant has an eligible condition, ASD. Although Dr. Byrne was credible in her explanations as to why she does not believe claimant meets the diagnostic criteria in the DSM 5-TR, the opinions of Dr. Whitehouse, Dr. Pratt, and Dr. Wheeler, who all had the benefit of spending many hours assessing claimant, were more persuasive on this issue. Claimant's pediatrician and psychiatrist concur in the diagnosis.

6. A preponderance of the evidence established that claimant has significant functional limitations in self-direction. His impulsivity, aggression, and emotional dysregulation are well-documented and have necessitated hospitalizations and placement in a residential treatment center. At present, he requires around-the-clock supervision. Claimant is substantially disabled in self-direction due to his ASD, although his other conditions likely also play a role.

7. A preponderance of the evidence established that claimant has significant functional limitations in self-care. Notably, he persists on urinating and defecating in inappropriate places, does not clean himself, and cannot be unsupervised around food. These limitations are attributable to his ASD, although his other conditions likely also play a role.

8. The evidence established that claimant has challenges with social communication but was insufficient to establish significant functional limitation in expressive and receptive language.

9. Claimant has limitations in mobility. These limitations are primarily due to a neuromuscular condition. Although the evidence established that claimant's ASD complicates his ability to cooperate with exercise and diet recommendations, it was insufficient to establish significant functional limitation in mobility due to claimant's ASD.

10. Although claimant has normal intelligence, he is unable to access education outside of a residential treatment center with full-time supervision. The evidence established significant functional limitations in learning due to claimant's ASD, with his other conditions also contributing to his impairment.

11. The evidence established significant functional limitations in claimant's capacity for independent living relative to his peers, due to ASD, with his other conditions also contributing to his impairment.

12. Because claimant has established that he suffers significant functional limitations in four areas of major life activity, he has established that he is substantially disabled due to ASD. Claimant has met his burden of establishing that his eligibility for regional center services.

13. Claimant's parents argued that SARC did not follow its own procedures in assessing claimant, suggested that Dr. Byrne did not adhere to ethical guidelines for psychologists, and contended that SARC's denial of eligibility was motivated by a desire to avoid taking on a high-need client. These contentions are rejected. The evidence established that SARC's denial was based on its clinician's good faith assessment of his eligibility.

ORDER

Claimant's appeal is granted. Claimant is eligible to receive Lanterman Act services from San Andreas Regional Center.

DATE:

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 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.

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

SAN ANDREAS REGIONAL CENTER, Service Agency.

DDS NO. CS0020801

OAH No. 2024090935

ORDER DENYING APPLICATION FOR RECONSIDERATION

An Administrative Law Judge (ALJ) serving as a hearing officer from the Office of Administrative Hearings (OAH) issued a decision in this matter on June 23, 2025. On June 26, 2025, OAH received San Andreas Regional Center's (SARC or Regional Center) application for reconsideration of the decision under Welfare and Institutions Code section 4713. [All further statutory references will be to the Welfare and Institutions Code.] The application for reconsideration was timely submitted. Claimant filed an opposition on June 26, 2025. The undersigned hearing officer did not hear the matter or write the decision for which reconsideration is requested.

A party may request reconsideration to correct a mistake of fact or law or a clerical error in the decision, or to address the decision of the original hearing officer

not to recuse themselves following a request pursuant to section 4712, subdivision (g). (Welf. & Inst. Code, § 4713, subd. (b).)

Regional Center's Request to Correct Mistakes of Fact or Law

Regional Center seeks reconsideration on claimed mistakes of fact and law. Specifically, Regional Center states the grounds on the application for reconsideration as follows:

> The decision does not consider WIC 4512(l) and 17 CCR 54001(a)(2), which state the regional center sets the standard to determine substantial disability ("...as determined by the regional center..."). The record contains testimony from two regional center clinical psychologists regarding that standard and how standardized testing is used to help determine substantial disability and how standardized testing must be at or under the third percentile to be considered as evidence of substantial disability. The record contains voluminous documentary evidence, highlighted specifically in the regional center's argument and its witnesses, and confirmed by the claimant's own experts, that shows the claimant's testing does not meet that criteria.
>
> In failing to consider both WIC 4512(l) and 17 CCR 54001(a)(2) with respect to the regional center's argument and the overwhelming evidence, the administrative law judge has errored (sic). The regional center requests that

this evidence be considered and that the decision be amended to either overturn the original decision and/or to provide the factual findings and determinations regarding the documentary evidence and the regional center's argument as pertains to the above statute and regulation.

Claimant's Opposition

Claimant asserts that SARC has failed to meet the standard for reconsideration of a final decision, because SARC merely reargues points that were raised and rejected at the hearing. Furthermore, claimant contends that SARC did not present new evidence, did not identify a material factual error and did not point to an error of law in the decision. In particular, claimant opposes the request for reconsideration as follows:

> 1. The Regional Center's Request is Premised on a Misinterpretation of Governing Law
>
> The Regional Center erroneously asserts that Welfare and Institutions Code § 4512(l) and its implementing regulations grant it the authority to create its own eligibility thresholds, such as a rigid 3rd percentile cutoff. This is a fundamental misreading of the law. As established in Government Code § 11340.5, an agency cannot enforce internal guidelines or criteria as if they were law without formal adoption through the regulatory process. The Regional Center's attempt to impose a percentile cutoff found nowhere in statute is precisely the type of unlawful "underground regulation" this

statute prohibits. The role of the Regional Center is to apply the law—not rewrite it.

2. Controlling Precedent Forbids the Use of Restrictive Internal Standards

As detailed in Claimant's Rebuttal Brief (Ex. B867-B868), controlling legal authority has consistently held that Regional Centers may not narrow the scope of the Lanterman Act through internal standards. Cases such as *Association for Retarded Citizens v. DDS* (1985) 38 Cal.3d 384 and *Woods v. Superior Court* (1981) 28 Cal.3d 668 affirm that agency actions exceeding statutory authority are void. The Regional Center's insistence on its percentile standard asks this tribunal to ignore this binding precedent. Furthermore, the Regional Center's reliance on its own clinicians' conclusions is misplaced. As held in cases like *Ronald v. North Los Angeles Regional Center*, such opinions are not entitled to special deference and must be weighed against the entire evidentiary record.

3. Substantial Disability is Defined by Functional Limitations, Not an Arbitrary Percentile Cutoff

The Regional Center incorrectly argues that eligibility requires standardized test scores at or below the third percentile. Neither the Lanterman Act nor its implementing regulations impose this requirement. WIC § 4512(l) defines

"substantial disability" as a significant functional limitation in three or more major life activities. The law provides that this determination be based on a comprehensive review of evidence, including clinical judgment, educational records, behavioral observations, and testimony—not just test scores.

The Association of Regional Center Agencies (ARCA) explicitly cautions that "Scores DO NOT solely determine the presence or absence of substantial disability" (Ex. A316)—a directive the Regional Center now disregards. In contrast, Claimant submitted extensive evidence across all relevant categories, **including numerous standardized test scores falling below the 3rd percentile**, some of which were administered by the Regional Center's own psychologist (Ex. A20). The Administrative Law Judge properly considered the totality of the evidence, including testing results, expert testimony, educational records, and compelling input from those who have worked closely with [claimant], in concluding that he meets the statutory criteria for eligibility. [Bold in original.]

ANALYSIS

Regional Center requests reconsideration to correct a mistake or fact or law. The issue at the fair hearing was whether claimant is eligible for regional center services. Claimant has the burden to prove that he has a developmental disability and meets the criteria to be eligible for regional center services.

In the Decision, the hearing officer determined that claimant is eligible to receive Lanterman Act services from the Regional Center. The ALJ considered the testimony of 11 witnesses and the exhibits admitted into evidence, including 19 exhibits offered by SARC and over 55 exhibits offered by claimant.

Specifically, in Legal Conclusion 5, the hearing officer concluded that a preponderance of the evidence established that claimant has an eligible developmental disability, autism spectrum disorder (ASD). The hearing officer considered the credible testimony of SARC's witnesses, including the psychologist who opined that claimant does not meet the diagnostic criteria for ASD in the DSM 5-TR. However, the hearing officer concluded that the opinions of claimant's witnesses, including a post-Ph.D. fellow and two psychologists, who all had the benefit of spending several hours assessing claimant, were more persuasive on this issue.

SARC appears to argue that the hearing officer did not consider the applicable law for the definition of substantial disability. However, in Legal Conclusion 3 of the Decision, the hearing officer provided the definition of substantial disability as defined in section 4512, subdivision (l) and California Code of Regulations, title 17, section 54001. In addition, the hearing officer admitted Regional Center's Exhibit 20, the Association of Regional Center Agencies' Recommendations for Assessing "Substantial Disability" for the California Regional Centers, which refers to section 4512 and

California Code of Regulations, title 17, section 54001. It is also presumed that the hearing officer reviewed SARC's position statement that also referred to these provisions. Despite SARC's argument to the contrary, the hearing officer considered the correct law in the Decision.

Also, SARC argues that the Regional Center determines what is considered a significant functional limitation and that standardized testing must be at or under the third percentile to be considered as evidence of substantial disability. SARC's psychologist opined that claimant did not have significant functional limitations in learning based on the standardized cognitive testing. (Factual Finding 27e).

In Legal Conclusions 6, 7, 10 and 11, the hearing officer concluded that a preponderance of the evidence established that claimant has significant functional limitations in self-direction, self-care, learning, and capacity for independent living relative to his peers. The hearing officer also concluded that claimant did not have significant functional limitation in expressive and receptive language, or mobility. The hearing officer found that claimant suffers significant functional limitations in four areas of major life activity to establish that he is substantially disabled due to ASD. Overall, the hearing officer concluded that claimant's psychologists were more persuasive than SARC's psychologist on the issue of whether claimant has significant functional limitations in the area of learning. Despite SARC's argument to the contrary, the hearing officer analyzed and made appropriate factual findings based on the evidence presented at the hearing.

Even assuming claimant did not meet the level of significant functional limitation in learning based on his standardized cognitive testing score, the preponderance of the evidence still met the criteria to establish that he has significant functional limitations in three other areas of major life activity. Pursuant to section

4512, subdivision (l), the term "substantial disability" is defined as "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: (1) Self-care. (2) Receptive and expressive language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living. (7) Economic self-sufficiency." Based on the evidence, the hearing officer determined that claimant was substantially disabled in the areas of self-direction, self-care, and capacity for independent living relative to his peers, in addition to learning.

In conclusion, the hearing officer analyzed the facts and applied the law as presented at hearing. There are no mistakes of fact or law that require a correction in the Decision. For the reasons stated above, the application for reconsideration must be denied.

ORDER

The application for reconsideration is DENIED.

DATE: July 11, 2025

REGINA BROWN
Presiding Administrative Law Judge
Office of Administrative Hearings