BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

ALTA CALIFORNIA REGIONAL CENTER, Service Agency

DDS No. CS0025951

OAH No. 2025040693

DECISION

Hearing officer Patrice De Guzman Huber, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on October 1 and 3, 2025, January 26, 2026, and February 2 and 4, 2026, from Sacramento, California.

Claudia Menjivar, Esq., and Susan Sindelar, Esq., represented claimant.

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

Evidence was received, and the record was left open for the submission of written closing arguments. Claimant's closing argument was admitted as Exhibit UU

and his rebuttal argument as Exhibit VV. ACRC's closing argument was admitted as Exhibit 42. The record closed and the matter was submitted for decision on March 13, 2026.

ISSUE

Is claimant eligible for services from ACRC under the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code section 4500 et seq. (Lanterman Act)?

FACTUAL FINDINGS

Jurisdiction

1. Claimant is a 13-year-old individual who resides with his adoptive mother, father, and sister in Sacramento, California. Claimant was adopted by his mother and father in 2017. He was born premature to a mother who reportedly used alcohol and other drugs during pregnancy. Claimant was removed from his birth parents' custody at three and a half years old.

2. In 2017, claimant applied for eligibility for services with ACRC under the Lanterman Act. ACRC conducted a social assessment, reviewed claimant's records, and referred him to Katherine Redwine, Ph.D., a vendored psychologist, for a psychological assessment for autism and intellectual disability. Dr. Redwine assessed claimant in May 2017 and opined he did not meet the criteria for either autism or intellectual disability. Upon review of claimant's case, ACRC determined he was not eligible for regional center services.

3. In 2024, claimant again applied for services with ACRC under the Lanterman Act. ACRC reviewed the records from claimant's previous eligibility application, conducted a new social assessment, and referred him to Morgen Aita, Ph.D., a vendored psychologist, for a new psychological assessment. Dr. Aita assessed claimant in March 2025 and opined he did not meet the criteria for either autism or intellectual disability. Upon review of claimant's case, ACRC again determined he was not eligible for regional center services.

4. On April 1, 2025, ACRC issued a Notice of Action (NOA) reflecting its determination. The NOA provides:

> ACRC's multidisciplinary eligibility team reviewed all of the information and records it obtained for [claimant] and on 3/31/25 determined that [claimant] does not meet the criteria for regional center eligibility under the Lanterman Act because he does not have substantially disabling autism, cerebral palsy, epilepsy, intellectual disability, or a condition closely related to intellectual disability or requiring treatment similar to that required by individuals with intellectual disability.

The NOA advised claimant of his appeal rights.

5. On April 10, 2025, claimant's mother appealed the NOA on his behalf. Claimant's appeal states:

> Seeking qualification under Category 5. [Claimant] has been diagnosed with Alcohol Related Neurodevelopmental Delay (ARND). ARND requires treatment similar to that required

> by individuals with intellectual disability. His disability has been assessed, documented, and attested by his psychiatric and medical providers.

The matter was thereafter set for a fair hearing.

Claimant's Assessments

6. In addition to witness testimony at hearing, the parties presented extensive and voluminous documentary evidence of claimant's assessments and treatment notes by various providers. All of that evidence was carefully reviewed and considered. However, this Decision only briefly summarizes the most pertinent assessments to explain resolution of claimant's appeal.

7. On May 8, 2017, Dr. Redwine, a licensed clinical psychologist, performed a psychological evaluation of claimant at the request of ACRC. Dr. Redwine reviewed ACRC's social assessment, conducted a clinical interview with claimant's mother, observed and evaluated claimant, and administered the Wechsler Preschool and Primary Scales of Intelligence (WPPSI-IV) and the Adaptive Behavior Assessment System, Third Edition (ABAS 3).

Dr. Redwine diagnosed claimant with Speech and Language Disorder, Unspecified Language Disorder, and Post-Traumatic Stress Disorder (PTSD). She ruled out Attention Deficit/Hyperactivity Disorder (ADHD). She described her impressions as follows:

> [Claimant's] Cognitive abilities as measured by the WPPSI-IV fell into the Average range with regards to his Visual-Spatial abilities. His other composite areas were significantly

lower. While his Fluid Reasoning abilities fell in the Low Average range, his Verbal Comprehension, Working Memory[,] and Processing Speed indices all fell within the Borderline range resulting in a Full Scale IQ that was on the cusp between Borderline and Low Average. His pattern of composite scores is consistent with [claimant's] mother's concerns about his distractibility and memory problems, as well as language delays. [Claimant's] Adaptive abilities as measured by the ABAS-3 fell into the Extremely Low range overall, both overall and in each measured Adaptive domain area.

Given his measured Cognitive abilities reaching into the Average range with regards to his Visual-Spatial Index[,] [claimant] does not qualify for a diagnosis of intellectual disability. Children with a history of trauma and ongoing difficulties with anxiety and behavioral regulation often struggle to perform activities of daily living at a developmentally appropriate level and often struggle to maintain adequate attention.

It is this evaluator's opinion that [claimant] qualifies for a diagnosis of PTSD given his very early childhood experiences. He shows subsequent and ongoing anxiety symptoms paired with a speech and language disorder. Although he presents as significantly hyperactive and distractible[,] this evaluator felt that given his young age

> and trauma history[,] it was premature to assign him a diagnosis of ADHD.

8. On June 13, July 23, and August 9, 2019, Christy Shaw, Psy.D., a pediatric neuropsychologist, performed a psychological evaluation of claimant. She reviewed claimant's records including school records and Dr. Redwine's report. Dr. Shaw interviewed claimant's parents, observed and evaluated claimant, and administered: the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V); Wide Range Assessment of Visual Motor Abilities; Rey Complex Figure Test and Recognition Trial; Child and Adolescent Memory Profile; Kiddie Connor's Continuous Performance Test; NEPSY, Second Edition; ABAS 3; Behavior Assessment System for Children, Second Edition; and Behavioral Rating Inventory of Executive Functioning, Second Edition.

Dr. Shaw diagnosed claimant with Neurodevelopmental Disorder due to General Medical Condition, ADHD, combined presentation, and PTSD "by history." In her psychological assessment report, she described her impressions as follows:

> [Claimant's] ability to sustain attention, manage emotional responses, act impulsively, visually organize information, utilize academics functionally, along with suspected difficulties with additional executive functions (self-direction, problem solving, flexibility, rapid retrieval of information) can be best conceptualized as a Neurodevelopmental Disorder associated with birth trauma, suspected exposure to neurotoxicants in utero and history of substantiated emotional abuse.

> A Neurodevelopmental Disorder is a diagnosis used to describe a group of conditions with onset during the early developmental period. They are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from specific limitations of learning a control of executive functions, to global impairments of social skills or intelligence. A neurodevelopmental disorder can be directly associated with a known medical or genetic condition, which produces its own unique profile of performance, behaviors, and set of considerations. Repeat in utero exposure to teratogenic substances, birth trauma, and ongoing substantiated emotional abuse can have great impact to the development of a child.
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> As a neurodevelopmental disorder is associated with differences and/or impairments in growth/development of the brain and central nervous system, this condition will continue to require a consistent level of intervention and support that is tailored to his strengths and challenges over time.

9. On March 11, 2025, Dr. Aita, a licensed clinical psychologist, performed a psychological evaluation of claimant at the request of ACRC. Dr. Aita reviewed ACRC's records and claimant's school records, conducted a clinical interview with claimant's

mother, observed and evaluated claimant, and administered the WISC-V and the ABAS 3.

Dr. Aita diagnosed claimant with ADHD “Per History” and PTSD “Per History.” In his psychological assessment report, he described his impressions as follows:

> Reported concerns are learning and cognitive skills. [Claimant] was administered a battery of tests to measure his cognitive capabilities. [Claimant] performed in the Below Average range on the WISC-V (FSIQ [Full Scale IQ]= 82; GAI [General Ability Index] = 86) which is well above the delayed range. [Claimant’s] mother reported that [his] adaptive skills are in the Extremely Low range (GAC [General Adaptive Composite] = 63) which is within the Delayed range. Based on [claimant’s] history and current presentation, it is in this examiner’s opinion that he **does not** meet criteria for a diagnosis of Intellectual Developmental Disorder (Formerly referred to as Intellectual Disability in DSM-5). It is in this examiner’s opinion that [claimant’s] presentation is best understood through the context of his symptoms related to ARND and ADHD rather than Intellectual Developmental Disorder.

(Bold in original.) Dr. Aita testified at hearing consistently with his report.

10. On May 23 and 27, and June 2, 5, 10, and 16, 2025, Kristin Gross, Ph.D., ABPdN,[1] performed a psychological evaluation of claimant at the request of claimant's mother. Dr. Gross reviewed claimant's records including ACRC records and school records, conducted a clinical interview with claimant's mother, observed and evaluated claimant, and conducted collateral interviews of claimant's grandfather; claimant's psychiatrist; Roger Scott Akins, D.O., claimant's pediatrician; claimant's therapist; and claimant's teacher.

Dr. Gross also reviewed the Behavior Assessment System of Children (BASC-3), Behavior Rating Inventory of Executive Functions (BRIEF-2), Conners'3 [*sic*] (an ADHD assessment), and Social Responsiveness Scale (SRS). She administered the following tests: Children and Adolescent Memory Scale (ChAMP); Children's Memory Scale (CMS); Delis Kaplan Executive Function System (DKEFS); Feifer Assessments of Math and Writing (FAM, FAW); grooved pegboard; Kaufman-Test of Educational Achievement (KTEA-3); NEPSY-II, a developmental neuropsychological assessment; projective drawings; Receptive, Expressive and Pragmatic Language Test (CELF-5); Rey Complex Figure Test (RCFT); Robert's Apperception Test; Social Language Development Test (SLDT); WISC-V; Wechsler Individual Achievement Test (WIAT-IV); and Wisconsin Card Sorting Test (WCST).

Dr. Gross diagnosed claimant with Central Nervous System Disorder (secondary to birth trauma, likely neurotoxic exposure in utero, early neglect/trauma contributing to deficits of attention, executive functions, affect regulation, overall cognitive ability,

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[1] A credential indicating board certification by the American Board of Pediatric Neuropsychology in pediatric neuropsychology.

and information processing), Expressive Language Disorder, ARND "by history," PTSD "by history," and ADHD, "by history." She wrote a psychological assessment report summarizing her findings. She testified at hearing consistently with her report. In her report, Dr. Gross explained her impressions:

> For this evaluation, and commensurate with other reports, [claimant] presented as a socially motivated, kind[,] and endearing boy. When in a regulated state, he is very easy to convers [*sic*] and engage with, and can be affectionate (with his sister) and polite. He took pride in doing something right/well and in such moments, his affect brightened. Like in school, he worked hard on any given task and did not show frustration when struggling, and instead either became quiet (to not admit that he did not know something) or tried to sneak a peek to get the right answer.
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> Thus, and again commensurate with other's [*sic*] observations, [claimant] really wants to look capable but is insecure, does not ask for help (he may be confused about what to ask about)[,] and relies on other clues to help himself out. This may take a lot of energy out of him, especially in complex environments such as school, which he won't be able to sustain consistently. He likely releases pent up stress at home, a place usually with less concrete structure, predictability[,] and opportunities to model his behavior and responses, but also his safe space. Interestingly, [claimant] does not feel anger at home but in

school, likely as he recognizes his struggles compared to peers, which fuels already vulnerable self-esteem.

In addition, [claimant] thrives in trusting relations but is so sensitive to perceived or actual criticism. Given weaknesses to deficits in social cognition (i.e. theory of mind, perspective taking, understanding of context cues) he may misunderstand other's [*sic*] reactions (especially in group settings) and as he struggles negotiating peer conflicts, is left feeling misunderstood, confused[,] or unwanted. This is complicated by his history of insecure attachments and having to be disciplined for his early behavior more often and more harshly than neurotypical children. Thus, cognitive and environmental factors inform each other[,] and untangling them can be quite challenging for those working with and caring for him.

Testing certainly identified cognitive deficits within the context of low average to average intellectual ability. Although [claimant] presents with intact word vocabulary and conversational speech, he quickly struggles once higher order linguistic skills, expressive language, verbal abstraction, inferencing and deductive thinking is required (he does still [*sic*] well when immediate feedback is provided and when he can work in a step-by-step fashion). Given strengths in hands-on and visual-spatial skills (average to high average), social motivation, fluent verbal

output[,] and dedication to appear compliant and capable, he may sometimes appear as more capable than he truly is. He relies on modeling behavior to look like everyone else but is not always processing everything to then execute adaptively, fueling emotional overwhelm and confusion.

Adaptive skills, in addition to executive function challenges (especially switching, integration of complex information, independence in task completion), are vulnerable[,] and [claimant] has difficulty applying basic skills in life (e.g., has not learned the value of money; reading time). Impaired cognitive efficiency also impacts the ability to acquire new skills in the time expected (despite intact memory capacity) and demonstrate what he knows consistently and time efficiently. Thus, most things likely go too fast for [claimant] to take in, process[,] and adaptively respond to, further adding to confusion, then overwhelm and upset/reactivity.

Alongside past test results and current academic achievement, [claimant] is now reading just below grade level but really struggles in math (especially number sense, math concepts[,] and applications) and written expressing [*sic*] (spelling, understanding contextual conventions of written language[,] and composing written material). His great difficulty in expressing himself in writing is certainly confounded by expressive language challenges. This is of

great concern, given increasing demands on such in grades to come.

11. In her report, Dr. Gross further explained how claimant's ARND diagnosis affects his intellect and functioning:

> [T]he etiology of [claimant's] cognitive challenges in combination with the course and symptom presentation of his psychiatric issues are the result of a combination of likely genetic vulnerabilities, very low birth weight, suspected drug and/or alcohol exposure in-utero[,] and early neglect and possible traumatic experiences in a very sensitive period of brain development (i.e., first three years of life), now expressed in a functional disturbance that primarily disrupts self-regulatory, cognitive[,] and affective functions. Any of these factors alone but certainly a combination of them can have a detrimental effect on the development of the central nervous system (e.g., reduced cerebral cortex, enlarged ventricles, reduced or disorganized interneuron connections, breakdown of corpus callosum, increased levels of cortisone leading to reduced hypocampal as well as amydale volume).
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> Paralleling biological fundamentals of brain development, research has shown how early disruptive attachment relationships to the primary caregiver lead not only to disruptive relationships and psychological disturbances later in life but also alterations in neuronal activity that

> become ‘hardwired’ and disrupt especially affect- and self-regulation, social cognition[,] and the development of empathy, moral, memory functions, cognitive flexibility (i.e., certain forms of executive function deficits)[,] and self-reflection. . . .
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> . . . [Claimant] has learned to regulate at least in certain settings but remains vulnerable and dependent on others to navigate life and complex social situations, understand cause-effect relationships[,] and apply himself adaptively in tricky situations. Looking ahead, his challenges will continue to impact functionality and independence for years to come and into adulthood.

Additional Hearing Testimony

12. Dr. Akins testified. He has been claimant’s pediatrician since 2021. Dr. Akins is board-certified in developmental and behavioral pediatrics and is the medical director of the MIND Institute, which operates a Fetal Alcohol Spectrum Disorder (FASD) clinic. In February 2024, he wrote a letter supporting claimant’s application for regional center services. In his letter, Dr. Akins explained:

> [Claimant] has a history of developmental delay unspecified, ADHD-CT, PTSD[,] and Alcohol Related Neurodevelopmental Delay (ARND), with significant delays in adaptive function and impairment in judgment and working memory that impacts overall function in a manner similar to youth who present with intellectual disability. I

have had ample opportunity to witness his behavior and assess his level of cognitive function in these areas and have worked closely with his parents and care team at the MIND Institute and Sacramento County Health Center CIRCLE Clinic on his treatment plan and goals.

Although [claimant] can be a very sweet and caring child, he has severe delays and limited cognitive and adaptive functioning which cause difficulty with appropriateness in social situations, communicating, and understanding danger and safety. On formal assessment, he has demonstrated cognitive deficits, specifically in the areas of judgment, orientation, and memory. However, his primary area of difficulty results from a combination of dysregulation secondary to severe PTSD, coupled with difficulties with judgment, dysregulation and irritability that are the core features of FASD. These deficits significantly impact and limit him in numerous areas of his life and result [in] it being unsafe for him to be left alone[,] and he requires much more adult supervision than another child of the same age that does not exhibit this degree of impairment due to clear medical causes.

With regard to memory, [claimant] shows moderate to severe processing weaknesses, deficits in comprehension, processing skills[,] and working memory. He will attempt to complete tasks [at] school and at home but requires near

> constant prompting and 1:1 assistance to do so. [Claimant] is also not able to recall emergency information if he were to become lost. In terms of orientation, [claimant] has limited time sense, including awareness of time frames, as well as initiation and organization of tasks due to time expectations. He also has significant difficulty transitioning between activities or tasks. [Claimant] struggles to tailor his behavior to the environment he is in.
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> With regard to judgement, [claimant] has severe behavioral issues and has required intensive medication management with developmental and behavioral pediatrics and child psychiatry and is currently prescribed 4 psychotropic medications, while also participating in weekly individual therapy. He has previously required Wrap services[,] and his parents have completed extensive training in therapeutic, trauma informed therapy, yet [claimant] continues to present with frequent emotional outbursts that include aggression and unsafe and noncompliant behavior. He requires constant supervision and is commonly at risk secondary to impaired judgement. [Claimant's] disability is expected to continue indefinitely, and his need for supported direction and supervision are anticipated to increase with age.

At hearing, Dr. Akins further explained that claimant's diagnoses of ARND, PTSD, and ADHD have symptoms that overlap, and it is difficult to attribute specific

symptoms to a specific diagnosis. However, he opines that ARND is claimant's primary diagnosis, while PTSD and ADHD affect the degree of the severity of claimant's symptoms.

Dr. Akins has treated patients whose only diagnosis is Intellectual Developmental Disorder (IDD). He opines that the treatment claimant requires for his diagnoses and management of his symptoms is similar to the treatment needed by an individual with IDD. Some examples of this similar treatment include specialized academic instruction, training and support for activities of daily living, and behavioral therapy.

13. Lisa Stewart testified. She has been an ACRC intake specialist for four years. In that capacity, she reviews eligibility applications and reviews supporting documentation. She determined that Dr. Akins's letter was insufficient by itself to conclude that claimant is eligible for regional center services. Ms. Stewart recommended a reassessment of claimant.

14. Sabrina Motherspaw testified. She has been an ACRC intake specialist for over 11 years. She conducted a social assessment of claimant in July 2024. She first spoke with claimant's mother by phone and later met with claimant and claimant's mother in person. Ms. Motherspaw described claimant as quiet and shy, with a flat affect. She requested a psychologist to review his case to determine whether testing was needed. Upon review by an ACRC psychologist, claimant was referred to Dr. Aita for assessment. Thereafter, claimant's records, including Dr. Aita's assessment, were sent to Sindhu Philip, Psy.D., and Katherine Milroy, M.D., for an eligibility evaluation.

15. Dr. Philip testified. She has served as a staff psychologist at ACRC for 15 years and has significant experience performing and evaluating psychological

assessments. Dr. Philip has not personally evaluated claimant but served on the ACRC multidisciplinary eligibility team that evaluated claimant's case. In that capacity, she has reviewed claimant's records, including the psychological evaluations by Drs. Redwine, Aita, and Gross.

Dr. Philip opined that claimant does not have a condition similar to intellectual disability or that requires treatment similar to that for intellectual disability. She explained that conditions similar to intellectual disability include Borderline Intellectual Functioning and Global Developmental Delay. Claimant has not been diagnosed with either. Dr. Philip also gave examples of some treatments required by individuals diagnosed with intellectual disability, such as mobility training, adaptive skills training, and learning supports. Dr. Philip testified she did not see records showing claimant has been receiving similar treatments.

Dr. Philip noted that claimant's overall average IQ test scores, the variability in his psychological testing scores, and the absence of supports indicated in his Individual Education Plan (IEP) that are similar to the supports needed by individuals with intellectual disability demonstrate a lack of uniformity or consistency with respect to claimant's intellectual ability or adaptive functioning. She believes that more time and data will provide a clearer and ultimately more consistent picture of claimant's diagnoses, symptoms, and level of functioning.

16. Dr. Milroy testified. She is board-certified in general pediatrics and has served as a staff physician at ACRC for four years. Dr. Milroy has not personally evaluated claimant but served on the ACRC multidisciplinary eligibility team that evaluated claimant's case. In that capacity, she reviewed claimant's records, including medical records. The records do not establish a diagnosis of cerebral palsy or epilepsy. Dr. Milroy is not qualified to opine whether FASD is a condition closely related to

intellectual disability or that requires treatment similar to that for intellectual disability, but she believes FASD can increase the risk of developmental disability.

17. Claimant's mother testified. She described claimant generally consistently with the impressions of Drs. Redwine, Shaw, Aita, Gross, and Akins. According to claimant's mother, claimant has "big feelings" of anger and sadness that he struggles to address, in part because he is "not very verbal." Claimant has "difficulty focusing" and "completing tasks." He does not understand the concept of time. Claimant also has "larger memory issues" such as difficulty with object permanence. He forgets the names of people or places he does not often see. Claimant also has difficulty remembering the day's events. He receives supports at school through an IEP, such as speech and language supports and "pull out" time for math, language, and speech. Claimant requires prompting to take his medications, shower, brush his teeth, and change his clothes. He cannot make his own meals or feed himself without assistance.

Analysis

18. Claimant was never diagnosed with cerebral palsy, epilepsy, autism, or intellectual disability. The only qualifying developmental disability at issue is a "fifth category," a condition closely related to intellectual disability or that requires treatment similar to that for intellectual disability. (Welf. & Inst. Code, § 4512, subd. (a)(1).) Claimant contends his ARND is a disability that meets the "fifth category."

19. Dr. Redwine assessed claimant at four years old and concluded that at that age, claimant's struggle to perform activities of daily living at a developmentally appropriate level and to maintain adequate attention was attributable to his history of trauma and ongoing difficulties with anxiety and behavioral regulation. Dr. Shaw assessed claimant at seven years old and concluded that his symptoms and challenges

were due to a neurodevelopmental disorder as a result of his birth trauma, exposure to alcohol and/or drugs, and emotional abuse. Dr. Aita assessed claimant at 12 years old and concluded that his symptoms and challenges are "best understood through the context of his symptoms related to ARND and ADHD." Dr. Gross further explored claimant's ARND diagnosis and symptoms, as they relate to his intellect and functioning.

20. Dr. Gross credibly testified and described in her report claimant's deficits in intellectual functions, such as abstract thinking and learning from experience, and adaptive functioning in communication, social participation, and independent living. Claimant's records demonstrate the onset of these deficits occurred during his early childhood. Further, claimant's records as a whole, in addition to the credible testimony of claimant's mother and Dr. Akins, establish that, due to claimant's ARND diagnosis, alongside his PTSD and ADHD diagnoses, he struggles significantly with self-care, receptive and expressive language, learning, self-direction, and capacity for independent living. His need for supports and services is anticipated to increase as the demands of life and school also increase. Drs. Shaw, Gross, and Akins believe claimant's needs will continue indefinitely for the foreseeable future.

21. While Dr. Philip opined that more time and data would provide a clearer picture of claimant's intellectual ability and adaptive function, the preponderance of the evidence establishes that claimant suffers from a condition closely related to intellectual disability or that requires treatment similar to that for intellectual disability. Consequently, claimant is eligible for regional center services under the "fifth category," and his appeal should be granted.

22. At hearing, claimant argued that if found eligible, his eligibility date should retroactively be set to 120 days after ACRC conducted claimant's intake.

However, the scope of the fair hearing and this Decision is limited to the NOA and claimant's appeal. Neither document made any reference to a retroactive effective date of eligibility. As a result, this Decision does not make any particular finding as to an effective date of claimant's eligibility.

LEGAL CONCLUSIONS

1. Pursuant to the Lanterman Act, regional centers are responsible for providing or coordinating services for persons with developmental disabilities. A developmental disability is defined as:

> a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

(Welf. & Inst. Code, § 4512, subd. (a)(1).)

"Substantial disability" means:

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

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

(*Id.* at subd. (l)(1).)

2. As the applicant, claimant bears the burden of proving by a preponderance of the evidence that he is eligible for Lanterman Act services. (See Evid. Code, §§ 500 ["Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that [he] is asserting"] & 115 ["Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence."].) The term "preponderance of the evidence" means "more likely than not." (*Sandoval v. Bank of America* (2002) 94 Cal.App.4th 1378, 1387–1388.)

3. The preponderance of the evidence establishes that claimant's ARND diagnosis, in conjunction with his PTSD and ADHD diagnoses, results in a condition closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability. Further, the preponderance of the evidence establishes claimant's substantial deficits in self-care, receptive and expressive language, learning, self-direction, and capacity for independent living. When all the evidence is considered, claimant established he is eligible for regional center services under the Lanterman Act. However, this Decision makes no finding as to the effective date of eligibility.

ORDER

Claimant's appeal is GRANTED, and Alta California Regional Center's denial of eligibility for Lanterman Act services is REVERSED.

DATE: March 25, 2026

PATRICE DE GUZMAN HUBER

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.