BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

and

REGIONAL CENTER OF ORANGE COUNTY,

Service Agency.

DDS No. CS0026332

OAH No. 2025050196

PROPOSED DECISION

Erlinda Shrenger, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by videoconference on July 1, 2025, and September 22, 2025, November 7 & 21, 2025, and June 4 & 5, 2026.

Ublester Penaloza, Assistant Manager, Fair Hearing and Mediation Department, represented Regional Center of Orange County (Service Agency or RCOC).

Claimant was represented by his mother and conservator (Mother). (Claimant and his family members are identified by titles to protect their privacy and confidentiality.)

Oral and documentary evidence was received on the hearing dates. At the conclusion of the hearing on June 5, 2026, the record was held open to allow the parties to simultaneously file and serve their closing briefs by June 19, 2026, and reply briefs by June 26, 2026. The parties timely filed and served their closing briefs and reply briefs. Service Agency's closing brief is marked as Exhibit 36, and its rely brief is marked as Exhibit 37. Claimant's closing brief is marked as Exhibit Z16, and his reply brief is marked as Exhibit Z17. The parties' closing and reply briefs (Exhibits 36, 37, Z16, and Z17) are hereby admitted as legal argument.

Prior to the hearing start of the hearing on June 5, 2026, Mother filed Claimant's Urgent Motion for Procedural Review, Record Preservation, and Written Closing Brief; Formal Request for Challenge for Cause or Reassignment. Mother contends, in pertinent part, that she was subjected to a pattern of procedural restrictions that prevented her from creating a meaningful and reviewable administrative record. The ALJ granted Mother's request for written closing briefs, and the remainder of the motion was taken under submission. Service Agency opposed the motion for the reasons stated in its closing brief (Exhibit 36). Based on consideration of Claimant's Urgent Motion and Service Agency's opposition, Claimant's Urgent Motion is hereby denied. Throughout these proceedings, Mother was afforded a full and fair opportunity to present witness testimony and submit documentary evidence, examine Service Agency's witnesses, make arguments, and develop the record.

The documents offered by claimant and marked as Exhibits Z14 and Z15 at the hearing are hereby admitted. Service Agency had no objection to these two exhibits.

The record closed, and the matter was submitted for decision on June 26, 2026.

ISSUES

The parties agreed the following issues are presented for decision:

1. Should Service Agency be required to reimburse claimant's parents for chiropractic services provided to claimant retroactive to November 1, 2024?

2. Should Service Agency be required to fund for Vision Therapy for claimant for one 12-month period?

3. Should Service Agency reimburse claimant's parents for copayments for the following: (a) Wave Imaging; (b) speech therapy; (c) occupational therapy; (d) physical therapy; and (e) medical services related to neurology and allergy shot visits.

EVIDENCE RELIED UPON

Documentary: Service Agency exhibits 1 through 37; Claimant's exhibits A through Z17; R39 through R87; and R90 through R97.

Testimonial: Carie Otto, RCOC Area Manager; Rebecca Lech, RCOC Medical Consultant; Christine Espitia, RCOC Speech Pathologist Consultant; Crystal Chavez, RCOC Self-Determination Program (SDP) Coordinator; Gavin King, RCOC Service Coordinator; Dr. Kauser Sharieff; Dr. Marlene Elizalde-Peschek; Luis Andrade; claimant's father; and Mother.

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FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant is a 22-year-old conserved adult. Claimant is eligible for regional center services based on his diagnoses of Intellectual Disability and Autism. Claimant is a participant in the Self-Determination Program (SDP) as of November 1, 2024.

2. By a Notice of Action dated April 28, 2025, Service Agency notified Mother that her funding request for certain of claimant's services was denied as follows:

> RCOC is not able to fund for Chiropractor Reimbursement, Vision Therapy, CT-Imaging Co-Pay Reimbursement, Occupational Therapy, and Speech Therapy since there may be funding available from [claimant's] three different insurance programs. RCOC must ensure all generic resources have been exhausted, and RCOC must receive a copy of all insurance responses to the physician and specialist request.

(Exh. 2.)

3. On April 29, 2025, Mother filed an Appeal Request to appeal Service Agency's denial of (1) reimbursement for claimant's chiropractic services retroactive to November 1, 2024; (2) funding for Vision Therapy; and (3) reimbursement for co-payments paid by claimant's parents for Wave Imaging; speech therapy; occupational

therapy; physical therapy; and medical services related to neurology and allergy shot visits. (Exh. 1.)

Claimant's Medical Insurance

4. Prior to September 2022, Mother's employer-provided medical insurance was through United Health Care. Claimant's Applied Behavior Analysis (ABA) services through Autism Behavior Services Inc. (ABSI) were covered under that insurance.

5. Effective September 1, 2022, Mother's employer-provided medical insurance changed to Anthem Blue Cross. Claimant's ABA services through ABSI was not covered under this new insurance. ABSI was not an in-network provider with Anthem Blue Cross. Anthem Blue Cross denied Mother's request for a single case agreement and would not contract with ABSI for claimant's ABA services. Claimant's parents escalated the issue to the California Department of Managed Health Care (DMHC). In the interim, Service Agency funded claimant's ABA services with ABSI from September 1, 2022, through January 31, 2023. Ultimately, the DMHC ordered Anthem Blue Cross to reimburse for the ABA charges incurred up to that time.

6. Effective February 1, 2023, claimant's parents purchased secondary insurance through Blue Shield of California (Blue Shield) so that claimant could continue his ABA services with ABSI. ABSI was an in-network provider with Blue Shield. When claimant's ABA provider changed to ABA LA, Mother cancelled the Blue Shield insurance effective July 1, 2025. ABA LA is covered under the family's primary insurance with Anthem Blue Cross.

7. Claimant also has insurance with Medi-Cal through Cal-Optima. Claimant has had Medi-Cal insurance through institutional deeming since he was a child. Medi-Cal does not cover claimant's ABA services.

8. In summary, claimant's primary insurance is with Anthem Blue Cross, and his secondary insurance is with Medi-Cal through Cal-Optima. Additionally, from February 1, 2023, through July 1, 2025, claimant had coverage under the Blue Shield insurance privately purchased by his parents.

Chiropractic Services

9. Mother has requested reimbursement from Service Agency for claimant's chiropractic services with Verve Chiropractic retroactive to November 1, 2024. Mother seeks a total reimbursement of $2,680.

10. Service Agency contends Mother's request for retroactive reimbursement for claimant's chiropractic services should be denied. Service Agency contends Mother has not provided sufficient documentation to establish insurance denials for chiropractic services and exhaustion of generic resources. Service Agency also contends no persuasive evidence was presented establishing a nexus between claimant's qualifying developmental disability, i.e., autism, and the requested chiropractic services.

FAILURE TO PROVIDE INSURANCE DENIAL DOCUMENTATION

11. Pursuant to Welfare and Institutions Code (Code) section 4659, subdivision (d)(1), a regional center is prohibited from purchasing medical services for a consumer "unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial" and the regional center determines that an appeal of the denial does not have merit.

12. Mother contends she has provided Service Agency with documents it has requested regarding claimant's chiropractic services. Claimant's closing brief states

that, on March 10, 2025, Service Agency was "supplied the Verve [Chiropractic] medical-necessity letter, billing and [Explanation of Benefits](EOB) information[.]" (Claimant's Closing Brief, p. 3 of 15.) However, the exhibits referenced in the Closing Brief for this contention do not include documentation of an insurance denial as required under section 4659, subdivision (d)(1). The closing brief references Exhibits Y, Z6, pages B1734-B1735, and Z4.

13. Exhibit Y contains several documents. There is a letter dated February 18, 2025, by Marlena Borst, D.C., who has treated respondent at Verve Chiropractic since September 30, 2024 (pages 1428-1429); Verve Chiropractic Orange invoices dated from September 2024 to May 2025 (pages B1430-B1482); an Explanation of Benefits statement from Blue Shield of California for chiropractic services on April 10, 2025 (page B1496); and the CalOptima/Medi-Cal Member Handbook (pages B1497-B1644).

14. Exhibit Z6, pages B1734 to B1735, is a printout of email communications between Mother and claimant's service coordinator, Gavin King. Mother's March 10, 2025 email states, in part: "I am attaching the medical necessity letter from Verve [C]hiropractic. Verve will not accept insurance, and I got the EOB from Anthem stating that they are out of network provider." (*Ibid.*) The medical necessity letter referenced in Mother's email is presumed to be Dr. Borst's letter dated February 18, 2025 (Exhibit Y), which is discussed more fully below.

15. Exhibit Z4 consists of notes and communications between Mother and service coordinator Gavin King from approximately March to April 2025, and RCOC ID Notes (pages B1849 to B2005).

16. Despite the number of pages of documentary evidence submitted by Mother for the hearing, there is no documentation of an insurance denial for

claimant's chiropractic services. Mother is not excused from the requirement under Code section 4659, subdivision (d), to provide such documentation just because the family's preferred chiropractic provider does not accept insurance or is not an in-network provider under the family's insurance. Mother's failure to provide the insurance denial documentation required under Code section 4659, subdivision (d), prevents Service Agency from funding (or providing reimbursement for) claimant's chiropractic services.

INSUFFICIENT EVIDENCE OF NEXUS BETWEEN CHIROPRACTIC SERVICES AND CLAIMANT'S DEVELOPMENTAL DISABILITY (AUTISM)

17. It was not established by sufficient evidence that chiropractic services are medically necessary to address claimant's developmental disability, i.e., autism, or that such chiropractic services are directed toward alleviating claimant's developmental disability. (See Code, § 4512, subd. (b).)

18. Mother provided Service Agency with a letter dated February 18, 2025, by Marlena Borst, D.C., of Verve Chiropractic. (Exh. Y.) That letter, however, does not establish chiropractic services as medically necessary to address claimant's autism. The letter establishes the medically necessity of chiropractic services for claimant's neck and back conditions described in the letter.

19. Claimant has been under Dr. Borst's care since September 30, 2024. In the letter, Dr. Borst wrote that claimant was diagnosed on September 30, 2024, with segmental and somatic dysfunction of the cervical, thoracic, and sacral regions. Dr. Borst's letter notes that claimant "has previously been diagnosed with Autistic Disorder early on in life" and "has a history of aggressive behaviors, incontinence, tension, and stiffness." (Exh. Y, +p. B1428.)

20. Dr. Borst summarized the rationale for her chiropractic treatment of claimant as follows: "Specific diversified adjustments to the areas of tension and of lack of motion, helping reduce overall tension in the body to reduce stress in the nervous system. The improved nerve signaling and reduced tension will help reduce any tension in the neck/midback/lowback that may be contributing to tension, stiffness, and general discomfort which may exacerbate his aggressive behaviors." (Exh. Y, p. B1429.) In her letter, Dr. Borst concludes that chiropractic is "medically necessary and reasonable" to treat claimant's neck, mid-back, and lower back conditions, and "Autistic disorder." (*Ibid.*)

21. Dr. Borst's letter is insufficient to establish chiropractic services as a medically necessary and reasonable treatment for claimant's autism. The Lanterman Developmental Disabilities Services Act, Code section 4500 et seq. (Lanterman Act), requires that assessments "shall be conducted by qualified individuals." (Code, § 4646.5. subd. (a).) Dr. Borst is a chiropractor. The scope of chiropractic practice is to manipulate and adjust the spinal column and other joints of the human body, and the muscle and connective tissue related thereto. (Cal. Code Regs., tit. 16, § 302.) Dr. Borst's conclusory statement that chiropractic services are medically necessary and reasonable to treat Autistic disorder is speculative and insufficient to establish a nexus between claimant's developmental disability, i.e., autism, and the requested chiropractic services. Dr. Borst's chiropractic services are directed towards alleviating claimant's neck and spine conditions, and are not directed towards the alleviation of claimant's developmental disability.

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Vision Therapy

22. Mother requested that Service Agency fund Vision Therapy for claimant for one 12-month period, starting March 1, 2026. Claimant began receiving Vision Therapy in May 2022.

23. As previously noted, a regional center may not purchase medical services for a consumer unless the regional center is provided with documentation of an insurance denial. (Code, § 4659, subd. (d)(1).) Additionally, regional centers shall not purchase "experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe." (Code, § 4648, subd. (a)(17).)

24. Rebecca Lech is RCOC's Medical Consultant. Her educational and professional background as a Doctor of Osteopathic Medicine is summarized in her C.V. (Exh. 7.) Dr. Lech credibly testified that Mother has not provided Service Agency with a medical referral for vision therapy; she (Dr. Lech) was not given documents regarding a medical need for vision therapy that is related to claimant's developmental disability; and Service Agency was not provided documents establishing that claimant exhausted generic resources prior to requesting funding for vision therapy.

25. Dr. Lech credibly testified that she found nothing in the medical literature she reviewed indicating that vision therapy is an evidence-based treatment for autism. Service Agency contends vision therapy has not been clinically determined or scientifically proven to be an effective treatment for autism. As such, it is considered experimental and cannot be purchased as Mother requests.

26. In support of her request for vision therapy, Mother presented documentary evidence and the testimony of Kauser Sharieff, O.D., FCOVD, and FNORA.

(FCOVD stands for Fellow of the College of Optometrists in Vision Development, and FNORA stands for Fellow of the Neuro-Optometric Rehabilitation Association.) Dr. Sharieff testified she is a "neurodevelopmental rehabilitation doctor," which she explained is an optometrist with a specialty in neurodevelopmental disorders. She has 28 years' experience in this field.

27. Dr. Sharieff testified that vision therapy is an evidence-based therapy for adults with autism. When asked for the basis for that testimony, Dr. Sharieff suggested a Google search for the Neuro-Optometric Rehabilitation Association (NORA), which studies and treats the symptoms of people with neurological dysfunction. Dr. Sharieff explained that scientific groups are not knowledgeable about neuro-optometry, so groups like NORA and COVD were formed.

28. Dr. Sharieff began her testimony in this hearing on September 22, 2025. Mother completed her direct examination, but Service Agency did not have sufficient time to complete its cross-examination. The fair hearing was not completed on September 22, 2025. Additional hearing days were set for November 7 and 21, 2025. Dr. Sharieff indicated she would return on November 7 to complete her testimony. When the hearing resumed on November 7, Mother informed the ALJ that Dr. Sharieff would not be appearing to complete her testimony. Mother explained Dr. Sharieff's testimony was only for rebuttal to any RCOC witness testimony regarding medical necessity.

29. Dr. Sharieff's incomplete testimony is not sufficient to establish vision therapy is an evidence-based treatment for autism. Service Agency did not have the opportunity to complete its cross-examination of Dr. Sharieff. As such, Dr. Sharieff's testimony is entitled to less evidentiary weight and not sufficient to refute Dr. Lech's credible testimony that vision therapy is not an evidence-based treatment of autism

and considered experimental. Service Agency's motion to exclude Dr. Sharieff's testimony is denied.

30. By an email sent on March 30, 2025, Mother provided Service Agency with a medical necessity letter by Dr. Kauser and also informed Service Agency that vision therapy was not covered under her insurance. The email stated, in part: "I am also attaching the medical necessity letter from Dr. Kauser. Vision therapy is not a covered benefit from my insurance, so there is no need to submit [a] denial letter from my insurance." (Exh. Z6, p. B1753.) Mother's assertion is incorrect. Service Agency cannot purchase a medical service, like vision therapy, unless it receives documentation of an insurance denial. Mother is not excused from the requirement to provide documentation of an insurance denial merely because the requested service is not covered by her insurance. A letter of denial from the insurance company, and not Mother's own statements, is required to prove exhaustion of insurance as a generic resource.

31. Mother's funding request for vision therapy must be denied on the basis that generic resources have not been exhausted, Mother has not provided the required documentation of an insurance denial, and vision therapy is considered an experimental treatment for autism.

Reimbursement for Co-Payments

32. Service Agency contends it should not be ordered to pay for claimant's co-payments for Wave Imaging, speech therapy, occupational therapy, physical therapy, neurology services, and allergy shot visits. At the time of Mother's requests for co-payment reimbursement, claimant was covered by primary insurance (Anthem Blue Cross) and secondary insurance (Medi-Cal through Cal Optima). Under the

Lanterman Act, regional centers are required to pursue and utilize all available generic resources, including insurance, before regional center funding may be considered. (Code, §§ 4648, 4659.)

33. Service Agency notes Mother has repeatedly asserted that generic resources have been exhausted. However, in this hearing, Mother failed to provide complete and persuasive evidence demonstrating that all available insurance coverage had been exhausted or that claimant's secondary insurance carrier had denied responsibility for the requested co-payments, with one exception. Mother's evidence included a CalOptima letter dated January 15, 2026, indicating that a claim for out-of-network services with Newport Beach Neurology Center was denied, thus establishing the exhaustion of a generic resource for this service. (Exh.Z15, p. Z122,) With the exception of the service provided by Newport Beach Neurology Center, Service Agency did not receive the documentation necessary to establish that all generic resources have been fully exhausted.

34. Regarding co-pays for speech therapy, occupational therapy, allergy services, claimant's closing brief acknowledges that some of the underlying insurance claims remain pending, unresolved, or subject to further CalOptima review. (E.g., Claimant's Closing Brief, pp. 9, 10.) The possibility that insurance could later deny, recoup, or shift financial responsibility does not establish that RCOC funding was appropriate at the time of the Individual Program Plan (IPP) team's determination. The Lanterman Act does not require a regional center to assume prospective responsibility for speculative future copayments or insurance determinations that have not yet occurred.

35. Mother's requests for reimbursement of co-payments for wave imaging, speech therapy, occupational therapy, physical therapy, and neurology and allergy

shots must be denied due to the failure to prove exhaustion of generic resources, i.e., claimant's primary and secondary insurances.

Other Findings

36. The ALJ considered all evidence and argument presented by the parties. Any evidence or argument not specifically referred to in this Proposed Decision was deemed not relevant, not supported by the evidence, not persuasive, duplicative, surplusage, and/or not necessary for the resolution of the issues presented in this case.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. A consumer seeking to obtain funding for a new service has the burden to demonstrate that the funding should be provided, because the party asserting a claim or making changes generally has the burden of proof in administrative proceedings. (See, e.g., *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789, fn. 9.) As claimant is seeking funding for previously unfunded services, i.e., reimbursement for chirpractic and vision therapy services, and co-pays for speech therapy, occupational therapy, physical therapy, Wave Imaging, and neurology and allergy visits, claimant has the burden of proving by a preponderance of the evidence that he is entitled to the requested services and funding. (See Evid. Code, § 500.) A preponderance of the evidence means evidence that has more convincing force than that opposed to it. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

Lanterman Act

2. The Lanterman Act governs this case. Claimant, through Mother, timely requested a fair hearing and jurisdiction for this case was established. (Factual Findings 1-3.)

3. The Lanterman Act requires an IPP to be developed and implemented for each individual who is eligible for regional center services. (Code, § 4646.) The IPP includes the consumer's goals and objectives as well as required services and supports. (Code, §§ 4646.5, 4648.) The services and supports included in an IPP must be "directed toward alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of an independent, productive, and normal life." (Code, § 4512, subd. (b).) While a consumer and his family's preferences and desires are to be considered in the planning process, regional centers are not authorized to purchase every service a consumer or his family may desire. A regional center's purchase of services must reflect a "cost-effective use of public resources." (Code, § 4646, subd. (a); see also Code, § 4512, subd. (b).)

4. The planning process for an IPP comprises "[g]athering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers and concerns or problems of the person with developmental disabilities." (Code, § 4646.5, subd. (a)(1).) Under Code section 4646.5, assessments are to be conducted by qualified individuals. The assessment includes information from the consumer, the consumer's family, the providers of services and supports, and other agencies. Based on the assessments, the IPP identifies the type and amount of services and supports to be purchased from the regional center or obtained from generic agencies or other resources to achieve the IPP goals and objectives as well as the

service providers responsible for attaining such goals and objectives. (Code, § 4646.5, subd. (a)(5).)

5. A regional center must utilize generic services and supports if appropriate to provide for the services and supports identified in the IPP. (Code, § 4646.4, subd. (a)(2).) Regional center funds cannot be used to supplant the budget of any agency that has a legal responsibility to serve the general public and that receives public funds for providing those services. (Code, §§ 4648, subd. (a)(8); 4685.8, subd. (d)(3)(B).)

6. Regional centers are required to "identify and pursue all possible sources of funding" from governmental entities such as Medi-Cal and private entities such as insurers. (Code § 4659, subd. (a).) And, except in certain circumstances not applicable in this case, regional centers are prohibited from purchasing any service otherwise available from Medi-Cal or private insurance when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. (Code, § 4659, subd. (c).)

7. Regional centers also cannot purchase medical services for a consumer three years or older "unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit." (Code, § 4659, subd. (d)(1).) Regional centers, however, may temporarily pay for medical services while coverage is being pursued but before a denial is made. (Code, § 4659, subd. (d)(1)(A)-(C).)

8. If a service or support provided to a consumer 18 years of age or older, pursuant to the consumer's IPP, is paid for in whole or in part by the consumer's

health care service plan or health insurance policy, the regional center may, when necessary to ensure the consumer receives the service or support, pay any applicable copayment, coinsurance, or deductible associated with the service or support for which the consumer is responsible if both of the following conditions are met:

> (1) The consumer has an annual gross income that does not exceed 400 percent of the federal poverty level.
>
> (2) There is no other third party having liability for the cost of the service or support, as provided in subdivision (a) of Section 4659 and Article 2.6 (commencing with Section 4659.10).

(Code, § 4659.1, subd. (b).)

9. If the adult consumer's income exceeds 400 percent of the federal poverty level, a regional center may pay a copayment, coinsurance, or deductible for a service or support authorized by the consumer's IPP if the service or support is necessary to successfully maintain the adult consumer in the least restrictive setting and the consumer demonstrates one or more of the following conditions: (1) The existence of an extraordinary event that impacts the ability of the adult consumer to pay the copayment, coinsurance, or deductible; (2) The existence of a catastrophic loss that temporarily limits the consumer's ability to pay and creates a direct economic impact on the consumer; or (3) Significant unreimbursed medical costs associated with the care of the consumer. (Code, § 4659.1, subd. (d).)

10. Notwithstanding any other law or regulation which would allow funding for a service, regional centers "shall not purchase experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to

be effective or safe or for which risks and complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice." (Code, § 4648, subd. (a)(17).)

Analysis

11. Claimant failed to prove by a preponderance of the evidence that he meets the statutory requirements for regional center funding of chiropractic services with Verve Chiropractic or vision therapy, based on Factual Findings 4-31, or that he meets the statutory requirements for reimbursement of co-pays for Wave Imaging, speech therapy, occupational therapy, physical therapy, and medical services related to neurology and allergy shot visits, based on Factual Findings 4-8 and 32-35. Accordingly, claimant's appeal shall be denied.

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ORDER

Claimant's appeal is denied. Service Agency is not required to: (1) reimburse claimant's parents for chiropractic services for claimant retroactive to November 1, 2024; (2) fund for vision therapy for claimant for one 12-month period; and (3) reimburse claimant's parents for co-pays for Wave Imaging, speech therapy, occupational therapy, physical therapy, and medical services related to neurology and allergy shot visits.

DATE:

ERLINDA SHRENGER
Administrative Law Judge
Office of Administrative Hearings

PETE CERVINKA
DIRECTOR

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY
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GAVIN NEWSOM
GOVERNOR

July 22, 2026

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SUBJECT: Office of Administrative Hearings (OAH) Proposed Decision- OAH Number 2025050196

On July 6, 2026, the Department of Developmental Services (Department) received the enclosed Office of Administrative Hearings (OAH) Proposed Decision issued by Administrative Law Judge (ALJ) ERLINDA SHRENGER, pursuant to Welfare and Institutions Code section 4712.5, subdivision (e)(1). Pursuant to Welfare and Institutions Code section 4712.5, subdivision (e)(2), within 30 days following receipt of the proposed decision the Director of the Department may adopt the proposed decision as written or decide the matter on the record, including the recording, with or without taking additional evidence. If the director or their designee does not act on the proposed decision within the 30 days, the proposed decision shall be deemed to be adopted by the director. The proposed decision is automatically adopted as of close of business July 22, 2026, and is the Final Decision in this matter.

Each party is bound by this Final Decision. Either party may request a reconsideration pursuant to Welfare and Institutions Code section 4712.5, subdivision (a)(1), 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.

Please find attached a “What to Do After You get A Final Decision” document. Please review all materials provided carefully. Should you have any questions or concerns regarding this letter, please contact the Department’s Office of Community Appeals and Resolutions at (833) 538-3723, or via email at appealrequest@dds.ca.gov.

Sincerely,

MICHAEL MCNULTY
Branch Chief
Community Appeals and Resolutions

Attachments

BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

Claimant

Vs.

Regional Center of Orange County,

Respondent.

OAH Case No. 2025050196

RECONSIDERATION ORDER, DECISION BY THE DIRECTOR

RECONSIDERATION ORDER

On July 27, 2026, the Department of Developmental Services (Department) received claimant's application for reconsideration of a Final Decision issued by the Director on July 22, 2026.

The application for reconsideration is denied. A review of the Final Decision and record does not support a finding of factual or legal error, or failure of the Administrative Law Judge to disqualify themselves, that would change the Final Decision. The Final Decision remains effective as of July 22, 2026. All parties are bound by this Reconsideration Order and Final Decision.

Each party has the right to appeal the Final Decision to a court of competent jurisdiction within 180 days of receiving the Final Decision.

IT IS SO ORDERED on this day August 6, 2026

Original signed by

Katie Hornberger
Deputy Director, Division of Community Assistance and Resolutions