BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

Claimant,

and

Tri-Counties Regional Center,

Service Agency.

DDS No. CS0027807

OAH No. 2025061099

DECISION

Taylor Steinbacher, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter via videoconference on April 16, 2026. This matter was consolidated for hearing only with two additional appeals relating to the same claimant: (1) DDS No. CS0027806 and OAH No. 2025061085; and (2) DDS No. CS0027808 and OAH No. 202506111. Separate decisions are being issued in each appeal.

Attorney Donald Wood of Wood & Finck represented Tri-Counties Regional Center (TCRC).

Attorney Melissa Meira Amster of Amster Law Firm represented Claimant at the hearing. Claimant's father (Father) and mother (Mother) were present throughout the hearing. Claimant's name and the names of her family members have been omitted to protect Claimant's privacy.

Preliminary Matters

Oral and documentary evidence was received at the hearing on April 16, 2026. The record was held open until April 24, 2026, for the parties to submit closing argument by brief. On that date, TCRC and Claimant submitted closing briefs, which the ALJ marked and admitted as Exhibit 29 and Exhibit HH, respectively.

On May 8, 2026, the ALJ issued an order setting this matter for an additional day of hearing to occur on June 29, 2026. At the hearing in April, TCRC had proffered reasons to deny funding for Claimant's requested service on grounds not stated in the Notice of Action (NOA), even though the Lanterman Developmental Disabilities Services Act (Lanterman Act), which governs this dispute, requires TCRC to state all the reasons and the legal bases for those reasons in the NOA. (Welf. & Inst. Code, §§ 4701, subd. (a)(2), (4); and 4710, subd. (b).) (All undesignated statutory references are to the Welfare and Institutions Code.) This additional day of hearing was to allow Claimant to submit evidence to rebut any reasons for denial not provided in the NOA.

On June 1, 2026, Mother filed a motion to cancel the additional day of hearing and requested that the ALJ issue a decision based on the existing evidentiary record, as well as four new exhibits Claimant submitted that day.

On June 3, 2026, TCRC filed a letter with OAH asking for an additional two weeks to respond to Claimant's motion because counsel for TCRC was recovering from

a recent surgery, and because TCRC wanted time to review Claimant's new evidence and provide a written response.

On June 15, 2026, counsel for Claimant withdrew from this matter. Mother represented Claimant in this matter thereafter.

On June 16, 2026, Mother filed an additional request to cancel the June 29, 2026 hearing, on the ground that the additional day of hearing will cause increased financial and emotional burden on Claimant and her family.

Also on June 16, 2026, TCRC responded to Claimant's original request to cancel the hearing, stating that TCRC did not object to canceling the additional day of hearing, so long as it could introduce three additional documents as evidence to rebut the evidence Claimant submitted together with the motion to cancel the hearing.

On June 17, 2026, the ALJ granted Claimant's request to cancel the June 29, 2026 hearing, and ordered the parties to submit their objections, if any, to each party's newly submitted evidence by no later than June 22, 2026.

Neither party submitted written objections to the other party's evidence. The ALJ marked Claimant's four additional documents as Exhibits II through LL, marked TCRC's additional documents as Exhibits 30 through 32, and admitted all these exhibits into evidence. The record closed, and the matter was submitted for decision on June 22, 2026.

ISSUE

Should TCRC fund feeding therapy for Claimant?

EVIDENCE RELIED UPON

Documents: TCRC Exhibits 1–32; Claimant's Exhibits A–LL.

Witnesses for TCRC: Anne E. Little, M.D.; Jennifer Del Castillo.

Witnesses for Claimant: Father; Mother.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Claimant is a four-year-old girl who lives with Father, Mother, and her brother in the catchment area served by TCRC.

2. TCRC is a regional center designated by the Department of Developmental Services (DDS) to provide funding for services and supports to persons with developmental disabilities under the Lanterman Act. (§ 4500 et seq.)

3. Claimant began receiving services from TCRC under the Early Start program when she was nine months old. Claimant currently receives services from TCRC under the Lanterman Act with an eligible diagnosis of Autism Spectrum Disorder (ASD). TCRC issued an NOA and accompanying letter dated June 17, 2025, stating that it was denying Claimant's request for TCRC to fund feeding therapy for Claimant. The sole basis stated in the NOA for TCRC's denial of funding for this service was that Claimant had not yet exhausted other generic resources for funding this service, such as Medi-Cal, California Children's Services (CCS), and private insurance. (Ex. 4, pp. A26, A29.)

4. On June 23, 2025, Claimant filed a fair hearing request to appeal TCRC's decision to deny funding for the feeding therapy she requested. This hearing ensued.

Regional Center Evidence

CLAIMANT'S MEDICAL ISSUES RELATING TO FEEDING

5. TCRC is aware of Claimant's difficulties with eating, and it acknowledges that improvement of her self-care skills, which include eating, as a goal in her Individual Program Plan (IPP). Claimant's IPP states that:

> [Claimant] has a high risk of aspiration when consuming liquids. This is due to her diagnosis of Oropharyngeal dysphagia and Laryngomalacia. Due to this issue, it often leaves her dehydrated/constipated, which is very concerning for her family and medical team. She is consistently monitored for this condition by [her team of medical providers at Stanford University]. She was receiving weekly occupational therapy in Early Start with [a local service provider], which specializes in feeding support. The family has chosen to continue this therapy privately since Early Start services ended at 3 years old. She uses a thickener for all of her liquid intake that she consumes through a straw cup. She is able to use a spoon to feed herself some solids, but she still mostly prefers her hands to feed herself. She has not yet mastered using utensils or open cups. She tends to overstuff her mouth or take too

> large of bites, so her family always stays next to her during feeding times to prevent aspiration or choking.

(Ex. 5, pp. A42–A43.)

Jennifer Del Castillo

6. Jennifer Del Castillo is the Supports and Services Manager for Early Childhood at TCRC. In this role, Castillo supervises 14 support staff who administer services to persons under the age of six who receive regional center services.

7. Del Castillo has known Claimant since Claimant first entered the Early Start program at TCRC. She explained that, while Claimant was in Early Start, TCRC was obligated to pay for feeding therapy for Claimant as an "early intervention service." But once Claimant exited the Early Start program at age three, the burden shifted to Claimant to exhaust other sources for funding before TCRC would continue funding that service because, under the Lanterman Act, TCRC is a "payer of last resort."

8. Del Castillo testified that, when considering whether a client had exhausted other generic resources, TCRC "highly encouraged" parties to appeal service denials from other providers, such as private insurance, school districts, and other applicable agencies. However, Del Castillo also testified that TCRC did not have a policy or a practice of requiring its clients to completely administratively exhaust—in the legal sense—all possible appeals of service denials before TCRC would fund a service.

9. Del Castillo is aware of Claimant's parents' efforts to obtain reimbursement or funding for feeding therapy through their private insurance and is also aware that private insurance is paying 30 percent of the cost of that therapy. She

is also aware that Claimant's school district declined to provide feeding therapy. Del Castillo testified that she encouraged Claimant's family to appeal these funding denials, but was unaware if they had done so.

ANNE E. LITTLE, M.D.

10. Anne E. Little, M.D., is a licensed medical doctor who has worked with persons with developmental disabilities, including ASD, for over 40 years. (Ex. 28.) Dr. Little has worked with TCRC since 2012. She currently works as a vendored physician consultant for TCRC, reviewing regional center eligibility claims and reviewing claims for requests for medical disability services, medical equipment, and health needs.

11. Dr. Little testified at the hearing that she reviewed various medical records relating to Claimant in connection with her evaluation of whether TCRC should fund feeding therapy for Claimant, although she conceded she had never met Claimant or examined Claimant herself. While Claimant was in the Early Start Program, Dr. Little noted that, with respect to her feeding difficulties, Claimant:

> is also known to have delayed oral motor skills with oropharyngeal dysphagia, delayed swallow onset, and history of aspiration. Her medical care for these diagnoses, including ongoing evaluations with treatment recommendations and guidelines, are provided by the Aerodigestive Team at Stanford [University]. [Claimant] receives specialized pediatric feeding therapy provided locally by [a local provider with an SWC designation] (SWC is an Advanced Practice credential for swallowing,

> assessment, evaluation and intervention). [The local provider's] most recent feeding progress summary (August 2024) noted that [Claimant] has made slow, but steady progress in her oral sensory-motor and feeding skills within the context of the guidelines recommended by the Stanford [University] Aerodigestive Team.

(Ex. 12, p. A136–A137.)

12. Dr. Little opined that she would not recommend that TCRC fund feeding therapy for Claimant. This is because it is her understanding that the regional center has a duty to fund only those services that alleviate or treat Claimant's developmental disability of ASD. According to Dr. Little, ASD does not affect the brain's control of the swallowing muscles such that Claimant's difficulty feeding is attributable to Claimant's ASD. Dr. Little conceded that there may be other diagnoses that regional center clients may have, such as cerebral palsy or brain injury, that can affect the muscles that control swallowing, but Claimant does not have such a diagnosis. Thus, because Claimant's issues with feeding are unrelated to her ASD diagnosis, it is Dr. Little's opinion that the regional center should not fund that service.

13. Dr. Little was unmoved by Claimant's evidence of medical studies and research papers discussing possible links between ASD and feeding or swallowing disorders. (See Exs. BB, DD.) According to Dr. Little, the medical literature linking ASD to feeding or swallowing disorders does not focus on the voluntary control of muscles in the mouth and throat, but discusses behavioral issues related to ASD and feeding such as food aversion, sensory issues, mealtime behavior issues, and eating food too quickly causing aspiration. Dr. Little would therefore recommend that TCRC fund a service to address behavioral issues attributable to ASD in the context of feeding. But

in the absence of evidence that Claimant exhibits behavioral-related feeding issues, or a finding from Claimant's medical team at Stanford University that her physical feeding difficulties are related to her ASD diagnosis, Dr. Little does not believe that TCRC is the appropriate agency to fund feeding therapy for Claimant.

Claimant's Evidence

FATHER'S TESTIMONY

14. Claimant lives at home with Mother and Claimant's older brother, who is also a TCRC client. Claimant was first diagnosed with ASD in October 2024. Claimant has been diagnosed with several other medical and developmental issues, such as speech and language disorder, global developmental delay, dysphasia, and was very recently diagnosed with Pediatric Acute-onset Neuropsychiatric Syndrome. Claimant has private healthcare insurance with Blue Shield California through Father's employer. (Exs. I, J.) Claimant also has secondary healthcare coverage through Medi-Cal/CenCal.

15. Father testified, consistent with Del Castillo's testimony, that TCRC told Father and Mother that although the regional center would fund feeding therapy and speech therapy for Claimant with local providers while she was in the Early Start Program, once Claimant exited that program at age three, Claimant's parents would need to look to other generic resources to fund those services, such as Claimant's school district, private health insurance, and Medi-Cal.

16. With respect to feeding therapy, Claimant continues to see the local provider recommended and funded by TCRC while she was in the Early Start Program. This provider, however, is not in-network with Blue Shield or CenCal, does not accept private insurance, will not file insurance claims for patients, and will not agree to execute a one-off "single case agreement," as suggested by TCRC. Moreover, no other

in-network providers within 15 miles of Claimant's home provide feeding or other therapy similar to what Claimant receives now. (Exs. M, O, R.) Father and Mother have spent hours investigating and contacting in-network providers for both Blue Shield and CenCal, trying to find a provider in their area offering similar feeding therapy but were unsuccessful—only their current feeding therapy provider offers that service in their local area. (Ex. S.)

17. Blue Shield initially refused to pay or reimburse Claimant's parents for any expenses relating to Claimant's feeding therapy, but ultimately agreed to pay 30 percent of those costs through reimbursement. CenCal is also a "payer of last resort" and thus requires participants to seek reimbursement from private insurance before it will provide coverage. Unlike Blue Shield, CenCal will not accept claims from providers outside its network and will not accept "self-claims" for reimbursement, and thus has rejected Father's attempts to have CenCal pay the remaining 70 of the co-pay for Claimant's feeding therapy. (See Ex. T, p. B135; Ex. Y.) Although Father believed that having primary and secondary health insurance coverage for Claimant would be helpful given her challenging constellation of healthcare needs, he discovered that having two insurance providers resulted in increased difficulties and complexities accessing services for aspects of Claimant's care needs.

18. From Father's perspective, there is no further way to exhaust his coverage with Blue Shield or CenCal to pay for Claimant's feeding therapy. Blue Shield is already paying 30 percent of the cost of that service, and that was only after he pushed them to do so. CenCal outright refuses to reimburse for services provided by any vendor outside its network, and no such vendors are local to Claimant.

19. Father is aware of the letter from Claimant's school district stating that the school district will not fund feeding therapy for Claimant because such therapy is

medical in nature and is not an educationally-related service. (See Ex. 27.) Father agrees with the school district's assessment that feeding therapy is not the responsibility of the school district given the district's educational prerogatives and did not appeal that determination further. Father acknowledged that, in theory, he could have appealed this determination, but because he agreed with it, and because he did not want to engage in a futile legal battle, he declined to do so.

20. Claimant's parents also consulted an attorney regarding Blue Shield and CenCal's refusal to pay for feeding therapy for Claimant, but were told that those appeals could take years, and that Claimant needs this service now for her own health, protection, and well-being.

21. Father believes that, of the many activities and therapies Claimant receives, feeding therapy is the highest priority for coverage or funding. According to Father, Claimant's ongoing issues with feeding affect her growth and safety, and are particularly troublesome to her parents who must constantly observe Claimant whenever she eats to ensure she is not silently aspirating.

MOTHER'S TESTIMONY

22. Claimant was born with a laryngo-cleft, which is an opening between the airway and the esophagus that caused food to enter the airway and resulted in increased risk of aspiration. Surgery to repair this cleft was successfully performed when Claimant was 15 months old. Despite the surgery's success, Claimant still has difficulty swallowing. All liquids fed to Claimant must be thickened, and food must be cut into small pieces and softened. Every meal requires Mother or Father to provide constant one-on-one supervision to ensure Claimant remains seated while eating and

does not silently aspirate. Mother described meals as very stressful and stated the family has not been able to have a "normal" family meal for years.

23. Claimant's medical team at Stanford University recommended Claimant go through a battery of testing, including a swallowing study and genetic testing, to determine the cause for Claimant's continued difficulty eating even after surgery. Despite undergoing all these recommended tests, Claimant's medical team has been unable to make a definitive conclusion about her continued feeding issues.

24. Claimant has improved her feeding abilities since receiving services from her feeding therapy provider. (See Ex. K.) Although Claimant still requires a thickener to consume liquids and eat certain foods, she now uses the lowest-level thickener whereas she previously used a much stronger thickening agent. Following Claimant's work with her feeding therapist, Claimant can now also drink from a cup.

CLAIMANT'S ADDITIONAL EVIDENCE

25. In connection with Claimant's request to cancel the additional day of hearing, Claimant submitted four additional exhibits, including two letters from Claimant's team of medical professionals. The letter from Sharon Watson, M.D., F.A.A.P., states that, despite Claimant's parents' efforts to address her feeding difficulties, Claimant still presents with "persistent oral-motor, sensory, and communication impairments associated with ASD [which] continue to compromise her feeding safety and speech development." (Ex. II, p. B427.) According to Dr. Watson:

> There is substantial clinical and empirical evidence that feeding difficulties and speech disorders are commonly associated with [ASD] and are frequently mediated by sensory processing differences, oral-motor dysfunction, and

> communication deficits. On the basis of my clinical evaluation and medical judgment, feeding therapy, and speech therapy (OMT) are medically necessary and are directly related to [Claimant's] qualifying conditions.

(Ibid.)

26. Similarly, a letter from Claimant's developmental pediatrician, Irene Koolwijk, M.D., MPH, states that:

> As part of the clinical assessment, [Claimant] demonstrates significant feeding difficulties since [birth], including food refusal, a limited food repertoire, gagging, sensory aversion, difficulty with textures, aspiration, and dysphagia. These feeding challenges are commonly associated with [ASD], particularly in children who experience sensory processing differences, heightened sensitivity to textures and tastes, and difficulty with oral-motor coordination. This aligns exactly with [Claimant's] case. Based on my clinical observations, [Claimant's] feeding issues are consistent with patterns frequently seen in children with ASD. These challenges may impact nutritional intake, growth, and daily functioning. For these reasons, I strongly recommend continued monitoring and interventions, which include feeding therapy, occupational therapy, and speech therapy (OMT), and other services as clinically indicated.

(Ex. JJ, pp. B428–B429.)

27. Finally, Claimant also submitted an updated "Occupational Therapy/Feeding Progress Summary" dated April 22, 2026, from her feeding therapy provider. That summary states that Claimant was recently administered the Pediatric Eating Assessment Tool (PediEAT) to assess Claimant's functional feeding skills. Claimant's scores on that assessment all indicated a "High Concern" score in her functional eating skills, except in one area that was scored as a "Concern." (Ex. LL.)

TCRC's Rebuttal Evidence

28. In rebuttal to Claimant's additional evidence, TCRC submitted three exhibits. TCRC's Staff Psychologist, Christina Aguirre Kolb, Ph.D., drafted a Clinical Interdisciplinary Note, in which she reviewed and considered the letters from Drs. Watson and Koolwijk, as well as the updated Feeding Progress Summary. (Ex. 30.) Dr. Aguirre Kolb concluded, contrary to Drs. Watson and Koolwijk, that Claimant's feeding issues can be addressed appropriately through Applied Behavioral Analysis (ABA). (*Id.* at p. A354.) Dr. Aguirre Kolb added that Claimant should continue attempting to exhaust generic resources through Claimant's school district. (*Id.* at p. A355.)

29. TCRC also submitted declarations from two other staff members: Veronica Rodriguez-Torrez, a Services & Supports manager, and Tamika Harris, a Services & Supports Assistant Director. (See Exs. 31–32.) Rodriguez-Torrez's declaration reiterates TCRC's service definitions for Occupational Therapy and for Speech, Hearing, and Language Services. (Ex. 31, p. A357.) Harris's declaration recounts the various parts of the Lanterman Act that TCRC asserts support its determination to deny funding for feeding therapy and reiterates that TCRC is denying Claimant's request to fund feeding therapy on the basis that other generic resources are available. (Ex. 32.)

LEGAL CONCLUSIONS

The Lanterman Act

1. The Lanterman Act governs this case. (§ 4500 et seq.) The Legislature enacted the Lanterman Act to provide a pattern of facilities and services sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life. The purpose of the statutory scheme is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Assn. for Retarded Citizens v. Dept. of Developmental Services* (1985) 38 Cal.3d 384, 388.)

2. DDS is the state agency charged with implementing the Lanterman Act; DDS, in turn, contracts with private, non-profit community agencies called "regional centers" to provide developmentally disabled persons with access to the services and supports best suited to them throughout their lifetime. (§§ 4416, 4620.)

3. Under the Lanterman Act, an administrative proceeding, also known as a "fair hearing," is available to determine the rights and obligations of regional centers and claimants when claimants disagree with a regional center decision. (§§ 4700-4717.)

4. Claimant requested a fair hearing under the Lanterman Act, and thus, jurisdiction for this case was established. (Factual Findings 1–4.)

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Standard and Burden of Proof

5. The party proposing a change in existing services or asserting a new claim holds the burden of proof in administrative proceedings. (See, e.g., *In re Conservatorship of Hume* (2006) 140 Cal.App.4th 1385, 1388 [the law has "a built-in bias in favor of the status quo," and the party seeking to change the status quo has the burden "to present evidence sufficient to overcome the state of affairs that would exist if the court did nothing"].) The standard of proof for these proceedings is the preponderance of the evidence because no other law or statute, including the Lanterman Act, provides otherwise. (Evid. Code, § 115.) This standard is met when the party bearing the burden of proof presents 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.)

6. Here, Claimant bears the burden of proving by a preponderance of the evidence that the regional center's denial of funding for feeding therapy was improper.

Individual Program Plan Process

7. The "services and supports" that regional centers can provide to a consumer include "specialized services and supports . . . directed toward the alleviation of a developmental disability . . . or toward the achievement and maintenance of independent, productive, and normal lives . . ." (§ 4512, subd. (b).) The determination of which services and supports are necessary for each regional center client is made through the IPP process with the regional center. (*Ibid.*) This determination "shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of

service options proposed by [IPP] participants, the effectiveness of each option in meeting the goals stated in the [IPP], and the cost-effectiveness of each option." (*Ibid.*; § 4646, subds. (a), (b) [noting that the IPP is developed through an "individualized needs determination" that includes the client as well as their parents, guardians, or authorized representatives, and should reflect "the needs and preferences of the consumer, and, as appropriate, their family"].) These cost control measures are in place to conserve resources that must be shared by many consumers. (See, e.g., §§ 4640.7, subd. (b), 4651, subd. (a), 4659.)

8. The IPP process includes "[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." (§ 4646.5, subd. (a)(1).) This information gathering process allows the regional center to "identify and pursue all possible sources of funding for consumers receiving regional center services." (§ 4659.)

Adequate Notice Under the Lanterman Act

9. When a regional center denies a service or support, it must provide claimants with "adequate notice" of its decision, including "[t]he reason or reasons for that action" and "[t]he specific provision or provisions of law, regulation, or policy supporting that action." (§§ 4701, subd. (a)(2), (4); and 4710, subd. (b).) As noted above, the sole basis stated in TCRC's NOA to deny Claimant's funding request for feeding therapy services was Claimant's alleged failure to exhaust all generic resources. TCRC also put on evidence through Dr. Little asserting an additional basis to deny funding in that feeding therapy would not alleviate Claimant's underlying diagnosis of ASD.

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10. At the conclusion of the hearing, the ALJ raised the issue of whether it would be appropriate to find TCRC could deny funding for feeding therapy services while relying on a reason not previously disclosed in the NOA and asked the parties to address that issue in their closing argument briefs, which the parties did.

11. Claimant was also given the opportunity to rebut the evidence of the additional basis for denial asserted by TCRC by setting the matter for another day of hearing. Claimant ultimately declined the opportunity to have another day of hearing and asked that this hearing date be canceled. Claimant did, however, submit additional documentary evidence rebutting TCRC's additional basis for denial, as noted above. Thus, to the extent that TCRC did not state grounds for denial in the NOA that it asserted at the hearing, Claimant has been given a fair and adequate opportunity to address that additional basis for denial.

Generic Resources

12. The IPP process must ensure conformance with the regional center's purchase of service policies and utilization of generic services and supports when appropriate. (§ 4646.4, subds. (a)(1), (a)(2).) While a regional center is obligated to secure services and supports to meet the goals of each consumer's IPP, a regional center is not required to meet a consumer's every possible need or desire but must provide cost-effective use of public resources. (See, e.g., §§ 4512, subd. (b), 4640.7, subd. (b), 4651, subd. (a), 4685, subd. (c)(3)(A), 4697, subd. (b)(2).)

13. Regional centers must "identify and pursue all possible sources of funding for consumers receiving regional center services." Those sources include, but are not limited to, Medi-Cal, school districts, and private health insurance providers. (§ 4659, subds. (a), (c).) If a generic agency fails or refuses to provide a regional center

consumer with those supports and services which are needed to maximize the consumer's potential for integration into the community, the Lanterman Act requires the regional centers to fill the gap (*i.e.*, fund the service) to meet the goals outlined in the IPP. (§ 4648, subd. (a)(1); *Assn. for Retarded Citizens*, *supra,* 38 Cal.3d at p. 390.)

14. Here, Claimant's IPP includes as a goal the improvement of her self-care skills, including safe feeding. (Factual Finding 5.) Under section 4659, TCRC identified in its NOA three possible sources for funding for feeding therapy that Claimant must identify and pursue: private health insurance, Medi-Cal, and Claimant's school district. (Factual Finding 3.) TCRC's additional evidence reiterated this as a basis to deny Claimant's request to fund feeding therapy. (Factual Finding 28.) Having identified possible sources of generic resources, the burden shifts to Claimant to show that these generic resources have failed or refuse to provide those services.

15. The evidence established that Father and Mother conducted an exhaustive search and invested several hours investigating, in good faith, each of these possibilities for complete funding of feeding therapy, without success. Father's undisputed testimony was that there are no providers within 15 miles of Claimant that provide pediatric feeding therapy that is like what she is already receiving from her local provider that are in-network for Blue Shield or CenCal such that all those costs would be covered. Blue Shield has agreed, after being pressed, to pay for only 30 percent of the cost of this therapy. Claimant's school district also declined to pay for this therapy, stating it is medical, rather than educational, in nature. (Factual Findings 14–21.)

16. Under these circumstances, Claimant has demonstrated that the applicable generic resources have either failed or refused to pay for feeding therapy such that the regional center may be relied on to fill that funding gap. Contrary to

TCRC's suggestion, nothing in the Lanterman Act requires a Claimant to take Herculean efforts to exhaust generic resources, such as litigating a funding denial to the highest possible court. On these facts, it is sufficient that Claimant has presented credible evidence about their reasonable and good-faith (but ultimately unsuccessful) efforts to exhaust the generic resources identified by the regional center.

Whether the Feeding Therapy Alleviates a Developmental Disability

17. As noted above, the Lanterman Act defines "services and supports for persons with developmental disabilities" as

> specialized services and supports or special adaptations of generic services and supports directed toward the 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.

(§ 4512, subd. (b).) These services and supports may include "physical, occupational, and speech therapy." (*Ibid.*)

18. Dr. Little opined that she would not recommend that TCRC fund feeding therapy for Claimant because of her understanding that the regional center has a duty to fund only those services that alleviate or treat Claimant's developmental disability of ASD. According to Dr. Little, because Claimant's feeding difficulties are unrelated to Claimant's developmental disability, the regional center may not pay for that therapy. But the Lanterman Act does not limit the services a regional center can provide solely to those related to alleviation of a client's developmental disability. Rather, the

regional center can also provide services that provide "physical . . . habilitation or rehabilitation" or those services that empower a person to live an "independent, productive, and normal life." It can hardly be said that learning to safely consume food would not provide Claimant with physical habilitation or rehabilitation, or that it would not empower Claimant to live an independent and normal life. Dr. Little's opinion does not appear to have accounted for "services and supports" providing anything but alleviation of a developmental disability, even though the statutory definition is not so limited.

19. Even assuming Dr. Little was correct, however, she also testified that she might revise her opinion about the appropriateness of TCRC funding feeding therapy for Claimant if there was some evidence from Claimant's care providers linking her ASD diagnosis to her dysphasia. The letters from Drs. Watson and Koolwijk provide this evidence. (Factual Findings 25–26.)

Disposition

20. Claimant has met her burden to show by a preponderance of the evidence that she has exhausted generic resources to fund feeding therapy for her and that TCRC is not prohibited from funding feeding therapy on the basis that feeding therapy would not alleviate her developmental disability.

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ORDER

Claimant's appeal is granted. TCRC shall pay the cost of feeding therapy services for Claimant, less any contribution from Claimant's private insurance provider.

DATE:

TAYLOR STEINBACHER
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 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.