BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

Claimant,

and

Westside Regional Center,

Service Agency.

DDS No. CS0029487

OAH No. 2025081118

DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on December 12, 2025, and February 12, 2026.

Susan Sindelar and Emily Ikuta, Attorneys at Law, Disability Rights California, represented claimant who was not present.

Aarone Abramowitz, Attorney at Law, Enright & Ocheltree, LLP, represented Westside Regional Center (WRC).

Oral and documentary evidence was received. The record remained open for the parties to submit written closing and reply briefs which were marked and received as the parties' arguments. Thereafter the record was closed, and the matter was submitted for decision on March 13, 2026.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) because his diagnosis of autism constitutes a substantial disability?

FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant, currently a thirty-five-year-old male, sought regional center services under the qualifying category of autism.

2. On August 13, 2025, WRC issued a Notice of Action (NOA) advising claimant that based upon its review of the assessments provided, although he had a diagnosis of autism, he did not have a substantial disability, which is required for eligibility for regional center services. WRC cited law in support of its determination and advised claimant of his appeal rights.

3. On August 19, 2025, claimant appealed the denial and asserted the intake/assessment procedures violated the Lanterman Act.

4. The appeal was forwarded to OAH, and the matter was set for hearing.

Evidence Introduced at Hearing

5. WRC staff psychologist Karesha Gayles, Psy.D., Pegeen Cronin, Ph.D., B.J. Freeman, Ph.D., and claimant's mother testified, and numerous documents were received. The factual findings reached herein are based on that evidence.

6. The parties' Position Statements set forth their respective positions.

Evolution of the DSM

7. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a publication by the American Psychiatric Association (APA) for the classification of mental disorders using a common language and standard criteria. It is the main book used for the diagnosis and treatment of mental disorders. There have been several editions and revisions made to the DSM since it was first published in 1952.

8. Earlier versions of the DSM used a multi-axial system, as claimant's records from those years demonstrated. The axes were a way for clinicians to record additional diagnostic information, and were organized into the following five-part axial system:

- Axis I, "Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention," identified the reason for the individual's presentation. The principal diagnosis or reason for the visit was listed as the first diagnosis when more than one Axis I disorder existed.

- Axis II, "Personality Disorder," listed the individual's specified personality disorders, mental retardation (the formerly used term), or prominent maladaptive personality features or defense mechanisms.

- Axis III, "General Medical Conditions," identified the individual's current medical conditions that were potentially relevant to understanding or managing the individual's mental disorder.

- Axis IV, "Psychosocial and Environmental Problems," listed the individual's negative life events, environmental difficulties, familial or interpersonal stresses, or other problems relating to the context in which the individual's difficulties had developed.

- Axis V, "Global Assessment of Functioning" (GAF), used a numeric rating system representing the clinician's judgment of the individual's overall level of functioning.

9. How autism is diagnosed has changed over time. At one point, "Autistic Disorder" and "Asperger's Disorder" were two separate diagnoses under the broader umbrella of Pervasive Developmental Disorders (PDD). To qualify for regional center services at that time, an individual had to have a diagnosis of Autistic Disorder; an Asperger's Disorder diagnosis was insufficient.

10. The DSM-5, published in 2013, eliminated the multi-axial system and GAF score, reclassified many disorders, and expanded the autism category such that Asperger's Disorder is now considered an autism diagnosis. The DSM-5 Text Revision (DSM-5-TR) was published in 2022.

11. The DSM-5and DSM-5-TR now have three "severity specifiers" for an autism diagnosis which "may be used to describe succinctly the current symptomatology . . . with the recognition that severity may vary by context and fluctuate over time." (DSM-5-TR, p. 59.)

12. Evaluators now identify whether the individual has mild symptoms and can function independently with support (Level 1), has moderate symptoms and requires substantial support (Level 2), or has severe symptoms and requires very substantial support (Level 3). (DSM-5-TR, p. 57.) The DSM-5-TR states: "[s]everity of social communication difficulties and restricted, repetitive behaviors should be separately rated. The descriptive severity categories should not be used to determine eligibility for and provision of services; these can only be developed at an individual level and through discussion of personal priorities and targets." (DSM-5-TR, p. 59.)The three severity levels are described in Table 2 as follows:

> **Severity Level 1, "Requiring Support"**
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> **Social Communication:** "Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful."
>
> **Restricted, repetitive behaviors:** "Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence."

Severity Level 2, "Requiring substantial support"

Social Communication: "Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication."

Restricted, repetitive behaviors: "Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and difficulty changing focus or action."

Severity Level 3, "Requiring very substantial support"

Social Communication: "Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches."

Restricted, repetitive behaviors: "Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action."

13. Claimant's severity level was at issue in this hearing. WRC asserted claimant had autism level 1, and did not have substantial disabilities in three of the seven required areas. Claimant asserted he had autism level 3, and had substantial disabilities in all seven areas.

DDS's Best Practice Guidelines

14. The California Department of Developmental Services (DDS) published *Autism Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis and Assessment* (Guidelines) in 2002. The Guidelines were created in collaboration with several individuals and organizations. Dr. Freeman was one of 15 individuals identified in Appendix M as being a member of the DDS Director's Advisory Committee on ASD who served as consultants on the creation of the Guidelines, providing input.

15. The Guidelines were issued to "strengthen and broaden the screening, diagnostic evaluation and assessment of ASD throughout California," which would "enhance the lives of the families and individuals who live with ASD and its effects every day." The Guidelines gave an historical and legislative background for its creation and identified its goals.

16. The Guidelines are divided into two sections, one for evaluating individuals from birth through age five and one for evaluating individuals age six and older. In this latter category, the Guidelines identify the nine components of an

evaluation, as well as the secondary components and differential diagnoses to consider. The Guidelines also point out the difficulty of diagnosing autism in older individuals, noting: "The older individual suspected of [autism] will require a more in-depth investigation and typically requires straightforward access to a specialist clinical team. Regional centers and other [autism] evaluation clinics offer the clinical expertise needed to evaluate complex cases presented by older individuals." (*Id.* at p. 78.) The complexity and variation in presentation of older individuals requires a coordinated team approach. It is important to investigate why the individual presented at a late age. (*Id.* at p. 79.)

17. Differentiating ASD from other diagnostic diagnoses "becomes a critical clinical issue" with older individuals. The "developmental expression of behaviors in both typical and atypical development in childhood and adolescence must be considered." It is "crucial to delineate" whether the individual's challenges can be better accounted for by other diagnoses. Diagnostic evaluations must address the factors that lead to an initial ASD diagnosis later in life because the reasons for a later diagnosis are "various and cannot be simplified through conceptualizations of 'missed' or 'misdiagnosed' ASD." (*Id.* at p. 79.)

18. "Best Practice: Differential diagnosis necessitates careful attention to clinical features consistent with both ASD as well as other disorders of childhood that have overlapping and coexisting symptoms." (*Id.* at p. 80.)

19. The Guidelines reference adaptive functioning evaluations, noting that many higher functioning individuals with autism, all scoring in the normal range on IQ tests, are functionally impaired in that they are unable to generalize or demonstrate their abilities in daily situations. (*Id.* at p. 102.) Higher-functioning individuals demonstrate wide discrepancies and often with ASD, social and communication

domains are significantly below estimated cognitive potential which appears to be more marked in children of higher ability. (*Ibid*.)

20. The Guidelines suggested adaptive behavior scales to evaluate adaptive functioning which include the Vineland, as well as other tests. A thorough evaluation of adaptive skills is necessary for diagnosis and intervention planning. Particularly with higher-functioning individuals, large discrepancies between cognitive performance and adaptive behavior indicate immediate targets for intervention and changes in instructional strategies. (*Id*. at p. 102)

ARCA Recommendations

21. ARCA's *Recommendations for Assessing "Substantial Disability" for the California Regional Centers* ("Recommendations") set forth recommendations for regional center Interdisciplinary Eligibility Review Teams (teams) to consider when determining whether an individual has a "substantial disability" in three or more areas of major life activity. The recommendations noted that the substantial disability impairments were expected to exist across multiple settings, be caused by the eligible condition, and be present before age 18. The recommendations advises users to also consider the "legal guidelines set forth in Welfare and Institutions Code section 4512, and California Code of Regulations Title 17, Sections 54000 and 54001."

22. ARCA's Recommendations note that scores on adaptive functioning measures do not solely determine the presence or absence of substantial disability because the scores are not a direct, objective measure of an applicant's adaptive functioning abilities. Thus, teams "should be vigilant to the potential for unintentional bias and/or the possibility of artificial over- or under-reporting of behaviors on these types of measures." Further an applicant's self-attestation should not be the sole

source of information to determine whether a substantial disability is present. Teams should also consider the amount, quality, and history of supports and look to obtain a wide variety of information.

23. The Recommendations set forth things to "consider" and "interview questions to ask" for each of the seven areas of major life activity to be evaluated.

Claimant's Past Medical Records

WASHINGTON STATE CHILDREN'S HOSPITAL RECORDS

24. Claimant introduced records from Children's Hospital in Washington which documented the treatment claimant received during his inpatient psychiatric hospitalization from January 3, 2003, through March 7, 2003, when he was 12 years old and in sixth grade.

25. The Children's Hospital records described claimant's diagnoses of anxiety disorder and obsessive compulsive disorder (OCD), his refusal to attend school due to anxiety, and how his anxiety had increased over time. Attempts to take claimant to school resulted in him crying, pulling his coat over his head, and curling up in a ball for several hours at a time, behaviors that were also observed at the hospital. Claimant's anxiety and OCD symptoms intensified around school issues and other topics such as exposure to insects, separation from his parents, and being around strangers. His anxiety and obsessive thoughts so intensified that claimant was hospitalized in the psychiatric unit where his anxiety and OCD behaviors were well managed in the hospital setting. However, he still experienced anxiety and obsessive thoughts that made it difficult to function at school.

26. The Children's Hospital records described claimant's participation in the hospital's school setting, noting that over time, his classroom and task demands steadily increased to the point where he was completing grade level work. Despite that steady progress, claimant sometimes demonstrated anxiety in the hospital classroom but was able to be academically productive when accommodations of a highly structured setting and a low student/teacher ratio were put in place.

27. The records documented that claimant initially exhibited a variety of maladaptive coping behaviors that decreased over time. His behaviors were interpreted as a function of his anxiety disorder, and he was given coping strategies for them. Claimant's scores on the Woodcock-Johnson II Tests of Achievement, a standardized assessments designed to evaluate cognitive abilities, academic skills, and oral language proficiency, were in the average range in all major academic areas. Recommendations following discharge were provided.

28. The report from the hospital's speech pathologist documented that claimant was functioning in the "solid average (if not above) range for his age in all areas of receptive language, expressive language, and word attack skills tested." However, he had significantly impaired speech intelligibility consistent with distorted articulation of "R" and "S" phonemes. The speech pathologist recommended school-based speech/language therapy and a social skills group to increase claimant's peer interaction and increase his self-esteem.

29. The hospital physician's March 2, 2003, Discharge Orders and Plan documented that claimant would be discharged home to his parents on March 7, 2003. The physician used the axial format, which was in place at the time, and gave the following diagnostic impression:

Axis I: OCD and Separation Anxiety

Axis II: None

Axis III: None

Axis IV: Problems with primary support group

GAF: 60 [GAF scores of 51-60 indicate moderate symptoms or moderate difficulty in social, occupational or school functioning]

30. The physician listed the medications prescribed to claimant and in the summary section wrote:

> [Claimant's] time was dominated by the sessions about his family's safety and complex compulsive rituals intended to protect them. He had not attended school due to anxiety in almost a year. He had a marked phobia to bugs. Distress tolerance skills were taught. [Claimant] was exposed to bugs with good success. Imagined exposure to going to school followed by two visits to his school were successful.

Children's Hospital's Psychiatry Report

31. A report signed by two hospital psychiatrists, one hospital psychologist, and claimant's hospital teacher, described claimant's emotional and behavioral difficulties to "support and expedite" consideration of claimant for special education services. Claimant had been admitted to the inpatient psychiatry unit when he presented with a long-standing history of emotional and behavioral difficulties related

to OCD and separation anxiety. He had been having serious school attendance problems since third grade. The summary of claimant's history was consistent with the records introduced at hearing, as detailed more fully below.

32. The psychiatry report noted how claimant's behaviors were consistent with one with OCD and described the treatment given for that disorder. The report described the school setting in which claimant participated while hospitalized, noting that he demonstrated a cognitive ability to complete grade-level academic work, but required extensive accommodations and staff support to acclimate to and remain functional in the classroom environment. Over time, claimant became more involved in the classroom setting as he became comfortable. However, despite his steady progress, he sometimes demonstrated anxiety in the hospital classroom. The psychiatry report contained several recommendations to address claimant's "extreme and long-standing history of [OCD] and Separation Anxiety with school refusal."

Children's Hospital's Therapist's Records

33. Records from the Department of Psychiatry's licensed family therapist, who treated claimant after he was discharged, documented her appointments with him. During the first visit on March 14, 2003, the therapist met with claimant and his mother. Claimant would not shake her hand or use of eye contact, provided brief answers, and displayed some speech and language problems. Claimant and his mother described claimant as having a "rough transition," and expressed disappointment with how the discharge planning went, indicating they thought, consistent with the psychiatry report's recommendations, that claimant would have a gradual exposure to school but instead, had been going back full-time. He had been sleeping in the counselor's office or in the library and had an increase in his intrusive thoughts.

34. The therapist documented the interests claimant shared with her, and also his difficulty answering a question. Claimant's mother described claimant's issues beginning in third grade and that although he was evaluated, she felt the physician minimized claimant's obsessions and compulsions and claimant's anxiety worsened. In 2000, claimant was followed by a psychiatrist who prescribed different medications, and claimant also saw a therapist, but they had not returned to the psychiatrist after claimant's hospital discharge because that psychiatrist does not treat OCD. (Of note, records of this 2000 treatment were not introduced.) Claimant's mother also described how things escalated after she was in a car accident which led to claimant's psychiatric hospitalization. She also reported that despite the family's hope that claimant would qualify for day treatment at Children's Hospital after discharge, it was determined his acuity was not high enough for that program.

35. A follow-up note documented the therapist's telephone conference with the discharge planning team, which included representatives from claimant's school and claimant's mother.

36. The therapist's March 26, 2003, note documented her second session with claimant and his mother, where she met "primarily with his mother" to advise her that the clinic would be closing and to discuss alternative providers.

TREATMENT WITH DR. ZANOLLI

37. A September 25, 2007, letter from Gerard Zanolli, M.D., a board-certified child, adolescent and adult psychiatrist, documented that claimant had been under his care since May 15, 2003. As with other records, the psychologists who performed WRC's eligibility evaluations did not list this letter as having been reviewed, and this treatment was not specifically referenced in their reports.

38. Dr. Zanolli's letter listed claimant's diagnoses as: Autistic Disorder (high-functioning); OCD; and bipolar disorder, not otherwise specified. Dr. Zanolli noted that claimant had attempted multiple trials of various medications without benefit prior to seeing him. There was a family history of bipolar disorder, attention deficit hyperactivity disorder (ADHD), anxiety, and depression, and one maternal uncle had committed suicide.

39. When Dr. Zanolli first saw claimant, his medications were Seroquel (an atypical antipsychotic used to treat schizophrenia, bipolar disorder, and major depressive disorder), clonazepam (a benzodiazepine used to treat certain seizure disorders and panic disorder), and clomipramine (a tricyclic antidepressant primarily used to treat OCD). Dr. Zanolli increased claimant's Seroquel "with good response," and added topiramate, an anticonvulsant used off-label for conditions like binge eating disorder and alcohol dependence, "for mood stabilization and weight control with partial response before it was discontinued." Claimant was started on gabapentin, an anticonvulsant, for OCD anxiety "with fair response." Claimant was started on Wellbutrin (an antidepressant) for "recurrent depressive symptoms with fair response." He was started on lamotrigine (an anticonvulsant used to treat bipolar disorder) "with good response," and he has taken alprazolam (a benzodiazepine used primarily to treat anxiety and panic disorders) "as needed for intermittent anxiety and agitation with good response."

40. Dr. Zanolli wrote that claimant would benefit from long-term psychiatric follow-up, including medication management and psychotherapy.

AUTISM CENTER, UNIVERSITY OF WASHINGTON RECORDS

41. Claimant introduced December 2003 records from Autism Center, University of Washington (Autism Center). Similar to the Children's Hospital records, the psychologists who performed the eligibility evaluations for WRC did not list these records as having been reviewed, although this assessment was referenced in the developmental history they obtained.

42. The Autism Center records contained claimant's past medical history which included hospitalizations at 13 months of age for RSV and again at 18 months for epiglottitis. The records also contained parental information, identified the specialists who had treated claimant and their diagnoses which were: ADHD, anxiety, severe anxiety, OCD, pervasive developmental disorder (PDD), and one pediatrician had diagnosed Asperger's syndrome. Claimant had received speech and occupational therapy services, as well as psychiatric services while hospitalized.

Dr. Levine's Report

43. The Autism Center records contained a report of the psychological evaluations performed by Ann Levine, Psy.D., on March 23, 2004, April 4, 2004, April 21, 2004, and June 17, 2004, when claimant was 13 years, three months old, and in seventh grade. Dr. Levine's report documented the referral and background information, past medical/developmental history, previous evaluation, and school information she obtained, and her behavioral observations.

44. In the "School" section, Dr. Levine documented that claimant's parents reported there were no significant concerns regarding school from kindergarten through second grade. However, they described claimant as "having a 'nervous breakdown'" during a spring break family trip to Europe when he was in third grade.

On vacation, claimant had difficulties crossing bridges, screamed, and ran away. Upon returning home, claimant refused to attend school. Despite attempts, including tutoring, claimant's anxiety increased and attempts to take him to school resulted in him crying, pulling his coat over his head, and "curling up into a ball for several hours at a time."

45. Dr. Levine's behavioral observations noted that claimant refused to come into the assessment room without his mother, muttered to himself, and spoke very softly to his mother. After a while, his mother was able to leave the assessment room. Claimant did not respond to praise but looked at Dr. Levine when praise was provided. His affect was flat. He persisted at tasks. During verbal tasks, he was slow to respond. During cognitive testing, he shrugged his shoulders or looked at Dr. Levine when he did not know the answer. His speech was characterized by articulation errors. He appeared passive as demonstrated by his remaining silent when he did not know the answers to questions. However, when Dr. Levine provided him with a choice, he appropriately responded, usually with: "'I don't know.'"

46. Dr. Levine administered the Autism Diagnostic Observation Schedule - Generic (ADOS-G) to claimant, which she wrote was "a standardized interview/observation instrument based on a sequence of structured and unstructured situations that are designed to assess social, communicative, and play behaviors." Dr. Levine noted that claimant presented "as a reticent young male who required encouragement and structure to engage in the interview."

47. Claimant's language did not contain stereotyped or idiosyncratic use of words or phrases. Overall, he had difficulty communicating in a reciprocal manner about a variety of topics. He spoke in detail about his animals but when Dr. Levine commented about animals, he had difficulty following her comments. Claimant's eye

contact was variable and he looked mainly at the floor while speaking. "He also infrequently used nonverbal gestures to communicate, and when this occurred he did not coordinate his verbal and nonverbal communication."

48. The social/emotional part of the ADOS-G showed that claimant demonstrated restricted shared enjoyment on a variety of tasks. He had difficulty sharing information and did not ask questions about Dr. Levine's interests. Claimant lacked a clear understanding of a variety of emotions. He could identify what he worried about, and reported using interventions he learned at Children's Hospital to decrease his anxiety. He had limited eye contact and his facial expressions were rarely directed toward others. He waited for Dr. Levine to initiate interaction, rather than initiate on his own. Even when discussing basketball, his affect remained flat and he did not elaborate his answers. Overall, claimant demonstrated a lack of insight about the nature of social relationships.

49. Sometimes claimant wrote his responses when he had difficulty verbalizing them. He was unable to explain what it meant to be a friend. He indicated that someday he would like to get married, explained that people do so "'so they don't have to be alone.'" He had difficulty differentiating between a friend and a schoolmate. He reported having no friends. He denied being teased but confirmed he sometimes bothers his sister, but could not explain what he did to annoy her. He denied experiencing loneliness and did not know if others felt lonely. During one discussion, claimant did not appear to understand or appreciate humor of the story discussed. Sometimes claimant remained silent until Dr. Levine provided increased structure. He had difficulty asking for help on complex activities, but could ask for help in more simplistic situations.

50. Dr. Levine administered the Vineland Adaptive Behavior Scales-Interview Edition (Vineland Scales) to claimant's mother, which is a standardized assessment designed to evaluate adaptive behavior and functional skills in individuals, particularly those with developmental disabilities. The Vineland Scales results indicated claimant was functioning well below his chronological age in the communication, daily living skills, which included self-care, and socialization domains. Overall, claimant's adaptive behavior skills were significantly weaker than his intellectual skills.

51. Dr. Levine administered the WISC-IV, an intelligence test which is an individually administered assessment containing fifteen subtests that provide a comprehensive assessment of intellectual ability. Dr. Levine noted that claimant's abilities could not be summarized with a single score because of the significant difference between his verbal comprehension reasoning and perceptual reasoning skills, with his verbal reasoning skills being weaker.

52. Claimant's scores indicated a possible language-based learning disability. He also demonstrated organizational difficulties when verbally formulating his ideas which could make social interactions frustrating if he cannot specifically and easily express his thoughts. In contrast, his nonverbal problem-solving skills were better developed than his verbal problem-solving skills. He displayed superior skills for working memory tasks. Attention/executive functioning testing showed that claimant had adequate abilities and adequate organizational strategies.

53. Using the former axial diagnostic format in place at the time, Dr. Levine had the following diagnostic impression:

Axis I: High Functioning Autism; Mood Disorder not otherwise specified; By history: ADHD, OCD, and symptoms of anxiety

Axis II: No diagnosis

Axis III: Sensory Integration Dysfunction (By history)

Axis IV: problems related to social environment (peers), and problems with education.

Axis V: Current GAF 41 [GAF scores of 41-50 indicate serious symptoms]

54. In her summary, Dr. Levine noted that claimant exhibited difficulties in all three areas involved in autism: (1) social interaction which included difficulty developing peer relationships, lack of spontaneous seeking to share enjoyment, and lack of social reciprocity; (2) communication which included his difficulty initiating and sustaining conversations and a history of restricted creative play; and (3) persistent interest in watching spinning objects and a skill for numbers. Although claimant had a strength for using gestures, he had difficulties coordinating gestures with eye contact. Claimant presented "with a profile of social and communication weaknesses in the presence of cognitive strengths." He was also "unable to translate his cognitive strengths into real life skills." He had difficulty articulating his distress, as well as identifying and discussing his emotions. He showed neuropsychological deficits associated with relative verbal-based language weaknesses which was most likely exacerbated by his anxiety and the social pragmatic difficulties children with autism have. He had difficulty generating problem-solving strategies and providing verbal reasoning which may be exacerbated by his anxiety.

55. Dr. Levine concluded that claimant "presents with a complex diagnostic picture including the history of attentional weakness, anxiety expressed via a fear of separation from his family and obsessive compulsive behaviors, motor tics (symptoms in 1998 which have subsided), subtle language weaknesses with regards to formulating/organizing verbal thoughts and documented history of impaired speech intelligibility." He had unusual behaviors that included commenting about how people smell, feeling like there was a magnet in his head, suspicious thinking - thinking his peers were watching him and that he may embarrass himself. He also had difficulties modulating his affect which was "likely related to a mood disturbance."

56. Dr. Levine found it to be a significant concern that claimant had not successfully been able to reintegrate into his class after approximately one year and continued to have significant social/emotional challenges in addition to his autism. As such, she strongly recommended that a therapeutic day school program or a self-contained special education program with emphasis on proven supports for children with autism and other comorbid conditions be considered. She opined that it was important for claimant to be with peers who have commensurate cognitive abilities. He had not benefited from his current program and the failure to provide an appropriate one for him "could result in loss of academic and social-emotional skills and contribute to loss of self-esteem."

57. Dr. Levine further opined that claimant should be qualified for school services as a student with "High Functioning Autism Disorder" and outlined the supports he needed, with a priority being placed on peer social skills and social problem-solving. Specific attention should also be paid to emotional regulation and structuring assignments in line with his conceptual abilities. Dr. Levine's report then provided her specific recommendations for those supports.

Comprehensive Psychiatric Evaluation – Final Report

58. The Autism Center records also contained "A Comprehensive Psychiatric Evaluation, Final Report," which was performed by Robert Devney, M.D., on June 17, 2004. Dr. Devney documented his evaluation of claimant, referenced Dr. Levine's testing, and claimant's inpatient hospitalization and his discharge diagnosis of OCD. Dr. Devney noted that claimant's pediatrician "wondered about autism spectrum disorder," and that Dr. Zanolli diagnosed claimant with pervasive developmental disorder and "treated him with clomipramine (started at Children's Hospital), Seroquel Topamax, and Neurontin." (Topamax is an anticonvulsant used to treat seizures and prevent migraine headaches. Neurontin is an anti-epileptic drug that treats seizures and nerve pain.)

59. Dr. Devney noted that since discharge, and on medication, claimant had been "fairly upbeat, talkative, dependent on structure and dependability," but he "will get depressed and cry if there is any change or transition," and some days was depressed. He was "moderately oppositional and defiant when asked to do things spontaneously." Claimant's obsessions and compulsions were "a lot better now," as he "used to be plagued with nearly continuous thoughts and rituals." He has ongoing conflicts with his older sister and has been aggressive at times.

60. "At school, things are going badly. His academics have been nearly nonexistent." Claimant had some minimal improvement the last few months, but his Individualized Education Plan (IEP) was very limited with "education occurring only three hours per day, and existing mostly in isolation." Claimant's grades were historically above average. His behavior showed "nearly total withdrawal," and he had a "nonexistent social life." He was "unable to participate in structured activities," and

his experiences in group activities were limited because of his "'shyness.'" After age seven, his group activity participation "began to go downhill."

61. Dr. Devney wrote: "This boy appears to have high functioning autism." He noted claimant had qualitative impairment in social interaction which was manifested by his marked impairment in the use of multiple nonverbal behaviors, failure to develop peer relationships appropriate to his developmental level, lack of spontaneous seeking to share enjoyment, interests and activities with others, and his lack of social emotional reciprocity. Claimant had qualitative impairment in communication manifested by his marked impairment to initiate and sustain conversations with others.

62. Dr. Devney further noted that claimant had restricted, repetitive and stereotyped patterns of behaviors, interests and activities manifested by his encompassing preoccupation with stereotyped and repetitive patterns of interest that were abnormal in their intensity and focus, by his apparently inflexible adherence to specific nonfunctional routines and rituals, and by his stereotyped and repetitive motor mannerisms.

63. Claimant had significant delays and abnormal functioning, which began before age three, in the areas of social interaction, language use, social communication, and to some extent in his symbolic and imaginative play. Claimant had moderate difficulties with inattention, forgetfulness, distractibility, and disorganization. He was only modestly impulsive and not hyperactive. His inattention symptoms occurred in a variety of venues and had been persistent over time. Claimant might have symptoms consistent with mild inattentive predominant ADHD.

64. Claimant had significant problems with mood. His reactive mood seemed to present that of a major depression, but there was a great deal of mood instability.

He had "several vegetative systems of depression." He had no history of mania or hypomania. He had a history of some marked temper tantrums, bordering on rage episodes, which were now occurring less often. He had psychotic features, including auditory hallucinations, visual hallucinations, and some paranoia which seemed "to be attached to his mood problems and his anxiety."

65. Claimant had many problems with anxiety and a generalized anxiety disorder. He had a history of separation anxiety disorder. He had multiple specific phobias and history of very severe OCD. Before receiving medication, his obsessions and compulsions "merely immobilized" him. They were now decreased, lasting one to three hours per day. Claimant's "social phobia is subsumed under his autism spectrum disorder." He also had significant problems with transitions, change, and emotional inflexibility which frequently led to meltdown-like behaviors.

66. Dr. Devney took a history and performed a mental status examination. Dr. Devney's DSM-IV diagnosis, which used the axial system formerly in place, was:

> Axis I: Autism (high functioning autism), with possible symptoms of ADHD, inattentive predominant type; OCD; generalized anxiety disorder; history of separation anxiety disorder; multiple specific phobias; anxiety disorder, not otherwise specified; mood disorder, not otherwise specified; and motor tic disorder
>
> Axis II: No diagnosis
>
> Axis III: Sensory integration dysfunction; mild asthma

Axis IV: Psychosocial stressors: father's mood and substance use problem, and financial problems

Axis V: GAF = 37 [GAF scores of 31-40 indicate some impairment in reality testing or major impairment in several areas, including work, school, family, or judgment]

67. Dr. Devney wrote that claimant had a complex presentation of neuropsychiatric difficulties. He "clearly has high functioning autism. As is often seen with those with autism spectrum disorders, he has problems with inattention. His inattention difficulties are, at present, subsyndromal in intensity." Claimant had problems with ruminations and frank obsessions and compulsions. His current medications helped to a moderate degree. He also had numerous other problems with anxiety and significant mood swings. He had frequent unstable moods, reflective of a mood disorder that was not well characterized, and it was "difficult to predict what will happen with this mood problem." Claimant's agitation and intermittent aggression were part of his mood problem and "part of his autism." He had some psychotic symptoms helped by medication which were "probably secondary to his autism, his mood, and his anxiety." He also had some motor tic problems. Dr. Devney made several recommendations which again noted claimant's complex problems which would require atypical medications, made medication suggestions, and recommended an IEP which was reflective of claimant's above average intelligence, significant disabilities, and significant sensory interrogation dysfunction.

DR. VINER'S REPORT

68. Claimant introduced a report from Mark W. Viner, M.D., a psychiatrist in Nevada, documenting his September 26, 2011, evaluation of claimant, who was then

20 years old. As with other records, the psychologists who performed the eligibility evaluations for WRC did not list this report as having been reviewed, and it was not referenced in their reports.

69. In the "History," Dr. Viner noted that claimant arrived with his mother, and "[h]is chief complaint is OCD, anxiety, eating disorder in this patient with 'High Functioning AUTISM' according to Mom." Claimant's "anxiety is so severe, that he was not able to go to school passed [*sic*] second grade." Claimant was under Dr. Zanolli's care in Washington "during childhood/adolescence," who started claimant on "this recent combination which he has been on since Sept. 2007." After moving to Nevada, "for the past four years, we started going to Dr. then moved here, for the passed [*sic*] has been going to [Dr.] Melinas X 1 year, Dr. Gonzales." [*sic*]

70. Claimant reported "recurrent disturbing and intrusive thoughts, refractory OCD vs mild psychotic process. Has Autism." Claimant's current medications included Lamictal. Wellbutrin, Xanax (a benzodiazepine used to treat anxiety disorders and panic attacks), and clomipramine. The Lamictal was not helping anymore, the Wellbutrin had been increased without much benefit, the Xanax led to "tolerance and dependence" and he "may get withdrawals if not taken," and clomipramine helped his OCD "at the beginning but it did not help that" now.

71. Claimant reported that he "hates going out in public alone, "his "OCD is very bad, about what he eats concerned about gaining weight, deprives self [*sic*]. Self starvation,." Claimant had been starving himself, "feels his body is distorted," "has to work out," and he "sees something in the mirror." Claimant "has symptoms of OCD," and the onset of his symptoms had been "insidious over a period of months." His symptoms "cause marked distress and significant impairment." Claimant "considers his

symptoms to be excessive or unreasonable." His symptoms are "intrusive and inappropriate excessively worse and worse. It is getting worse."

72. Claimant's brain "feels really clouded, feels more unable to complete past [*sic*] and starts thinking about it more and more." This "causes depression per mom." "Chronic symptoms of OCD are occurring." He has persistent and intrusive thoughts of an obsessive nature. "Intrusive thoughts about contamination or germs are present. Persistent, intrusive and unwelcome ideas of an aggressive or irreligious nature are described."

73. "When depressed, [claimant] hits self in head, picks fingers until bleeds, sometimes punches wall." He has "performed repetitive and persistent behaviors of a compulsive type in the past." Claimant has "[s]ymptoms of anorexia, with a refusal to maintain a normal weight." He "refuses to maintain a normal body weight. He expresses a fear of gaining weight."

74. Claimant denied "the seriousness of his medical condition. His self-image is unduly influenced by his body size and shape." Dr. Viner described claimant's behaviors regarding his body, exercise, diet, and symptoms of bulimia.

75. Claimant described feelings of general and separation anxiety. He was agoraphobic (an extreme or irrational fear of entering open or crowded places, of leaving one's own home, or of being in places from which escape is difficult), and tried not to be seen in public.

76. Claimant's obsessions made him depressed with little energy. He had no suicidality. Claimant "has symptoms of a depressive disorder." His obsessions precipitate his depression. He has had multiple prior depressive episodes.

77. Claimant had psychotic symptoms in the past. He used to have visual and auditory illusions, not necessarily hallucinations. At age 12 he could hear voices of his parents calling his name. One note documents the following: "[O]ne night illusions, look down and see leg bleeding. See little boy in the tree [*sic*]."

78. He reported cardiac episodes of skipped heartbeats or rapid heartbeats. He has had some blackouts and syncopal episodes, as well as episodes of dizziness. Dr. Viner listed claimant's diagnoses, past psychiatric history, psychiatric diagnoses, and psychotropic medications prescribed.

79. Dr. Viner took a social/developmental history, and a family history which noted that claimant's mother had anxiety and suicide in her family and claimant's father was bipolar and had alcoholism in his family. Dr. Viner also took a medical history, and performed a mental status examination. He noted claimant made no eye contact and was not very interactive. Claimant's speech, body posture and attitude, thinking, facial expression, and general demeanor revealed a depressed mood. Claimant's affect was "appropriate, full range, and congruent with mood." There were no signs of anxiety, hyperactive or attentional difficulties, or withdrawal. Dr. Viner's diagnostic impression, made in the former axial format in place at the time, was:

> Axis I: OCD Active; Major Depressive Disorder, recurrent, severe with psychotic features (Active); and Autistic Disorder (Active).
>
> Axis II: None
>
> Axis III: Medical History: Here Dr. Viner documented claimant's past medical history including right foot and left thumb surgery, concussion, RSV, paradoxical syncope, and

epiglottis, his adverse drug reactions, allergies, immunizations, current medical diagnoses of dizziness and asthma, current medications, claimant's denial of recreational drug use or admission to using it in moderation which was not felt to be a health risk, and unimpaired hearing and vision. Claimant described "current pain."

Axis IV: None

Axis V: 56 (Highest GAF in 12 months) [GAF scores of 51-60 indicate moderate symptoms or moderate difficulty in social, occupational or school functioning]

80. Dr. Viner's Plan included adding risperidone (an atypical antipsychotic used to treat schizophrenia, bipolar disorder, and irritability associated with autism) "for refractory illness . . . and autism since FDA approved," decreasing Xanax, lowering Wellbutrin, and continuing Lamictal and clomipramine. The Plan also called for psychotherapy for autism, depression, OCD, anxiety, to consider psychoeducation and individual and family therapy, and to monitor claimant's medications which included lab work. Claimant was to return in one month or earlier, but no other records from Dr. Viner were introduced.

Claimant's School Records from Washington State

81. Records from claimant's Washington school district, when he was in sixth grade, documented a request for Home/Hospital instruction completed by claimant's physician, who identified claimant's primary diagnosis as "OCD/severe, psychosis N/OS," and his "other" diagnosis as: "[claimant] is dealing with the severe [symptoms]

of OCD, anxiety." The physician certified that claimant was unable to attend public school for 12 weeks beginning November 30, 2002.

82. Special education records documented claimant's goals and progress. In January 2004 it was noted that claimant needed to work on eye contact, but, in June 2004, he was "doing well with eye contact when name is called."

TEAM EVALUATION REPORT

83. A March 2003 Team Evaluation Report documented that claimant was referred for an evaluation with the school psychologist on March 3, 2003, and that it was determined on March 31, 2003, that he did not qualify for special education services. The reason for the referral was because claimant was transitioning back to school after an almost two month stay at Children's Hospital's Inpatient Psychiatric Facility. Claimant "suffers from severe school-related anxiety and [OCD]." Claimant's teacher at the hospital had referred him for a special education evaluation in the "hopes that [claimant] would receive the services that his mental health providers believed he needed to be successful in his transition."

84. The school psychologist took a background history. Report cards documented that claimant had always been a strong student with above average academic abilities and performance, but beginning in third grade, he had missed a substantial amount of school which his mother said was due to his extreme anxiety. He began attending counseling to address his anxiety. Claimant repeated the pattern of having consistently strong grades but numerous absences. Although continuing to receive counseling, his mother reported he continued to display extreme anxiety around going to school. Despite being placed on the honors track for middle school,

he was unable to begin sixth grade "due to his severe anxiety." His parents and physician requested home hospital instruction for him.

85. Claimant initially began seeing a tutor, but then became too anxious to attend tutoring sessions or have tutoring in his home. He even began refusing to attend public events and by mid-December 2002, his fears had increased and he avoided all children and was unable to speak to most adults, became afraid people were talking about him, staring at him, or trying to annoy him, and in January 2003 he was admitted to Children's Hospital Inpatient Psychiatric Unit, where he stayed for approximately two and a half months. While there, he was followed by both a psychiatrist and a psychologist.

86. The report from the hospital documented claimant's OCD and his treatment that included medication, techniques, and teaching cognitive-behavioral strategies for anxiety reduction. Claimant's OCD behaviors while hospitalized were noted. Claimant's teacher at the hospital contacted the school psychologist to explain claimant's history and outline the services that were being recommended, which included continued outpatient psychiatric care at Children's Hospital for four to six weeks at the school district's expense which would consist of one half day at the hospital and one half day at school. The school evaluation team then determined that a full evaluation of claimant was appropriate.

87. The Team Evaluation Report noted that claimant was gradually reintroduced to school, without incident, but he did spend most of his time in the counselor's office and the library, although he did complete sixth grade testing and attended a reading class. The planned addition of small group tutoring activity did not occur due to claimant's apparent anxiety about that situation and his refusal to attend. Other than that instance of anxiety, claimant "appeared to be in control during the

school day." However, his mother reported he displayed "a great deal of anger at home." Claimant's outpatient therapist would attempt to assist claimant and his family with dealing with those episodes and claimant's "continuing anxiety and OCD symptomatology."

88. School staff attended the discharge meeting at Children's Hospital where a tentative schedule was put into place for claimant. The schedule included gradually increasing claimant's exposure to classrooms and staff, and explaining each new exposure increase to claimant well in advance and giving him input and veto power if he felt the task would be too difficult. Mondays were noted to be claimant's most difficult days. The Children's Hospital team advised that "task demands may not be appropriate for [claimant] this year," and believed claimant would have "a successful year if he is able to maintain full-time attendance for the rest of the year, regardless of whether he completes any schoolwork or participates in any classes." The hospital team also believed that "to successfully manage [claimant's] anxiety he will need a full-time one-on-one assistant to coach him on reduction techniques and support his academics." The requests for a one-to-one aide and funding claimant's aftercare hospital sessions were initially denied because claimant's need for special education instruction had not been established.

89. The areas the Team evaluated were organization, reading, study skills, cognitive, math, behavior, attention, written language, and personal/social. Those areas were assessed "using standardized, normal-referenced instruments: academic and social/emotional." Non-standardized/informal assessments were also used which included parent interviews, teacher interviews, and interviews with mental health providers.

90. The Team Evaluation Report set forth claimant's scores on various testing, including the Woodcock-Johnson Tests of Achievement - Third Edition, which were in the average and high average ranges, indicating his academic skill levels were at or above what would be expected for a child his age. The Behavior Assessment System for Children (BASC) - Teacher Report Form Adolescent was completed by claimant's Children's Hospital teacher. (The BASC is a comprehensive, multidimensional tool used to assess the emotional, behavioral, and social functioning of children and adolescents).

91. On the BASC, claimant's scores were in the caution range due to the teacher's responses regarding claimant's level of sadness and withdrawal, which were consistent with claimant's diagnoses. The areas of anxiety, atypicality, and withdrawal were in the clinically significant ranges, and claimant's constant worrying, strange ideas, and being out of touch with reality at times, were noted. It was found that those behaviors were consistent with claimant's OCD diagnosis. It was further noted that claimant was almost always shy with adults, had trouble making friends, and avoided other children. He often refused to talk, join group activities, and would change direction to avoid greeting someone. The areas that fell in the at-risk range were depression, somatization, social skills, leadership, and study skills. Claimant was noted to be "almost always" sad and easily upset. He did not encourage or compliment others. Claimant was sometimes creative and made decisions easily. He missed assignments and was not well organized, but he sometimes worked hard, completed homework, and had good study habits.

92. The Team Report noted that Children's Hospital reported that claimant had been given numerous anxiety-reduction techniques which he was able to use on his own or with prompting. He continued to receive outpatient counseling. Claimant

spent most of his day with the school counselor. The only time he exhibited outward signs of anxiety was when he was asked to join a small group tutoring session, but his anxiety was "quickly relieved" when he was told he did not have to attend. Other than that, claimant had been very compliant when back at school, was able to complete a full day of school, but spent his time in the counselor's office, his reading class, or the library. He wore headphones at all times, and spent most of his time reading. He often had the hood of his sweatshirt pulled over his head.

93. The Team Evaluation Report also noted that claimant was diagnosed with OCD and separation anxiety, and those disorders adversely affected his ability to attend school over the past three years and led to a psychiatric hospitalization. Although he "clearly meets eligibility criteria for the special education funding category of emotionally/behaviorally disabled, he does not appear to demonstrate need for specially designed instruction." His academic skills were in the average and high average ranges despite missing significant portions of his school years. He demonstrated numerous deficits in the areas of social/emotional skills, but had already been taught numerous anxiety-reduction techniques which he could perform on his own or with prompting. He was "currently being heavily accommodated in the school setting and will continue to need extensive accommodations to be successful in his recovery and in school." Additional accommodations might be offered if he begins attending more classes or was more comfortable with his peers. The school staff should work closely with claimant's parents and the hospital outpatient therapist to ensure that claimant's program was progressing at an appropriate rate.

94. On March 31, 2003, the school district's eligibility team determined that claimant "does not qualify" under any eligibility category. He did not qualify for special education services because he did "not demonstrate a need for specially designed

instruction" and his "mental health and educational needs can be met with accommodations implemented within the general education setting." The eligibility team recommended a 504 plan be provided to address claimant's numerous accommodations and modifications, and that plan be reviewed and modified frequently. (A 504 plan is a formal document developed under section 504 of the Rehabilitation Act of 1973, and is designed to provide accommodations and support for students with disabilities, ensuring they have equal access to education in general education classrooms.)

OCCUPATIONAL THERAPY REPORT

95. The school district's Occupational Therapy report noted that claimant had been screened by the occupational therapist in June 2002 and again in June 2003 to help with accommodations. He had received both a diagnosis of OCD and anxiety disorder from Children's Hospital and a diagnosis of "Asperger's from Dr. Melvin Morse." (Of note, Dr. Morse was not identified at hearing although WRC's evaluator's report summarized his records as noted below.) Claimant's mother "requested that the adolescent/adult sensory profile be administered" to claimant, and that the occupational therapist report her observations and suggestions.

96. "Dr. Morse reported a need for accommodations based on the Sensory Profile." Claimant's "[r]eported sensory integration difficulties were in the areas of 'sensory seeking, emotionally reactive, sedentary muscle and body tone, oral sensitivities, and being distractable and inattentive.'" Claimant's "[s]pecific difficulties were in 'auditory processing, vestibular processing, touch, oral sensitivities and multisensory processing,' also he has 'problems with functional emotional and behavior responses to sensory input.'"

97. The help with claimant's accommodations and the occupational therapy screening, the Adolescent/Adult Sensory Profile was administered. (The Adolescent/Adult Sensory Profile is a standardized assessment tool designed to evaluate how adolescents and adults respond to sensory experiences in their daily lives.) The Profile is completed by the student, as opposed to the parent, and is normed for the student's age. Claimant's scores on the four areas assessed were all "Similar to most people." Despite those scores, claimant "did have some significant patterns when looking at specific sensory areas," which included taste/smell and movement processing. His scores "were very interesting." He would not elaborate on his responses and often simply did not respond. His mother reported that he disliked smells and was a very picky eater. He also did not like people around him when he entered a new environment.

98. The occupational therapist documented the accommodations being provided. She noted the accommodations and recommendations were made primarily based on the fact that claimant had difficulty remaining in class, completing work, and tended to sleep a lot during school. His reported sensory issues would be used when implementing accommodations, and many of the accommodations the occupational therapist would suggest were "already being used."

IEP RECORDS

Seventh Grade

99. IEP records from 2003 when claimant was in seventh grade documented his social skill and behavior issues, as well as services and accommodations provided to address them.

100. Claimant qualified for speech services in the area of articulation. Claimant had been assessed at Children's Hospital where his receptive and expressive language skills were found to be within normal limits.

101. Claimant was administered the Wechsler Individual Achievement Test Second Edition with demonstrated significant deficits in the area of social/emotional skills. Although being taught numerous coping strategies to use during times of high anxiety, claimant demonstrated a need for specially designed instruction in the area of social skills. His time in special education class was "not yet participatory." His teacher advised that he attends class between 30 and 45 minutes, and is allowed to leave when necessary. Claimant was unable to interact appropriately with unfamiliar adults, his peers, and familiar adults other than his parents. The social skills curriculum would be provided to claimant's parents to work with him at home, the goal being transitioning claimant into the classroom setting.

Eighth Grade

102. IEP records from 2004 when claimant was in eighth grade documented various goals and services, including speech therapy and social skills. The social skills document referenced an IEP meeting where the minutes per week of social skills were listed. Claimant was able to complete eighth grade general education work, but due to his disability, was unable to access the curriculum within the general education setting.

103. January, April, and June 2004 speech therapy progress reports documented the improvements claimant had made in his speech.

104. A transition plan noted that claimant would need a specially designed program for instruction, but would not need ones for vocational education/training,

community experiences, employment or other post-school adult living, and acquisition of daily living skills.

105. The "Present Levels of Educational Performance" documented that claimant's social skills had regressed, and he was currently unable to enter the school building due to "severe school anxiety" and was currently receiving special education home instruction. Given claimant's issues, he was being placed in a special education/specialty school and speech therapy was being temporarily suspended until he began to be comfortable with his new program.

106. That report further noted that claimant was diagnosed with high functioning autism and a mood disorder. According to Dr. Levine's evaluation at University of Washington Autism Center, claimant had restricted shared enjoyment, limited eye contact, and a lack of insight into social relationships. He waited for others to initiate action with him, rather than initiate on his own. He did not use facial expression to communicate affect. He had difficulty asking for help, and lacked understanding of a variety of emotions. Claimant also had diagnoses of OCD and generalized anxiety disorder given by Dr. Devney, and was taking clomipramine, Seroquel, Topamax, and Neurontin. Claimant "enjoys the hoop shooting aspect of playing basketball." Claimant was unable to interact appropriately with familiar adults, other than his parents, unfamiliar adults, or his peers. When anxious, he tended to withdraw and when most anxious, he would sleep. He was able to complete the eighth-grade general education work but, due to his disability, was unable to access the curriculum within the general education setting.

107. Other documents referenced areas to address and summarized claimant's performance in those areas. Goals to address those areas were listed. The records also contained a transition plan for after when he graduated high school.

108. Records from claimant's specialty school documented claimant's progress, that he made friends, and how he had initiated interactions with peers. Records from the spring semester noted that he had made "significant gains in the area of peer interactions." He made "some solid connections with his peers." Claimant was able to speak his mind and share things about himself with others, and was more open to answering questions and giving comments during classroom discussions. He still had some difficulty in reading comprehension.

Ninth Grade

109. IEP records from 2005 when claimant was in ninth grade, noted that claimant's cognitive skills were not in question and academics were not an area of concern. Claimant had met all of his IEP behavior/social emotional goals and objectives and made significant social progress during the school year. He had made one close friend with whom he kept in touch outside of school and recently joined the YMCA with his family. He expressed interest in participating in more social activities, such as yoga or basketball, and his parents and teachers noted that he appeared to have an overall decreased level of anxiety. He also increased his level of communication with staff and peers. He actively participated in class discussions and was beginning to verbalize his wants and needs using words and phrases. He took pride in his work and was willing to accept advice from adults. His life skills and recreation teacher reported he was a pleasure to have in class and on outings. He was attentive to lessons, participated in whole group discussions, and completed his assignments. He was able to participate in all classroom outings. He had made tremendous progress at this new school and the IEP team was considering transitioning him, but wanted to see him find success first in another social environment. Specific interventions that contributed to claimant's overall progress

were listed which included behavior management systems, encouragement, and cognitive behavioral therapy with the school counselor, his accommodations were also referenced.

110. An IEP addendum when claimant was in ninth grade, dated January 19, 2006, documented the recommendation that claimant be dismissed from speech therapy because he no longer demonstrated a communication disorder and was 100 percent "intelligible at the word, sentence, and conversation levels." Claimant's parents and school staff no longer believed he needed speech therapy. The addendum documented claimant continued to meet eligibility criteria for special education services under the category of autism. "Social" was noted to be the area of specially designed instruction claimant required.

Tenth Grade

111. An October 16, 2006, "Evaluation Report," when claimant was in tenth grade at the specialty school, noted that he was evaluated to determine if he continued to be a special education student requiring those services. His eligibility disability category for special educations services was autism. The effects of claimant's disability was that he performed "substantially below the level of his peers in the area of social skills/behavior." To address that area, claimant "would likely benefit from small-group and individual instruction in self-advocacy skills, as well as social interaction skills."

112. The "Background" section of the report noted that claimant had "made a great deal of progress" at the specialty school and "developed into a funny, likeable, and generous young man that [*sic*] has been a role model for his peers. His IEP goals and objectives have progressed from focusing on very basic skills, such as making eye

contact and answering yes/no questions, to much more advanced skills, including serving as a peer mentor and providing peer support when asked and using verbal skills to communicate with peers." Claimant had "met these goals with 97-100% success."

113. The report noted further: "Due to his impressive progress, the IEP team determined claimant was ready to "begin a transition" to his local regular high school where he would attend two afternoon classes and attend his specialty school in the morning. Multiple planning meetings took place between the two schools and claimant's parents and claimant visited the campus to become familiar with it. He began at the regular high school on the first day of the 2006-2007 school year and once the transition began, claimant's parents reported he was having increased anxiety, depression, OCD behaviors, and lying on the floor for hours at the end of the day. "Though his teachers at [the regular school] did not notice [claimant] struggling in class," claimant reported feelings of social isolation and anxiety, so much so that in mid-September at the specialty school, he broke down in tears and said he thought he would have a panic attack if he had to return to the regular high school. A mentor was assigned to claimant at the regular school, but claimant was not interested.

114. The report stated that as the transition continued, claimant's parents reported he was becoming angry about the situation, felt other students were annoying, and that he was not getting the help he needed from teachers. The teachers continued to call on him despite his parents' many requests they not do so. Claimant and his parents felt the transition was not successful and felt it would be more appropriate to discontinue it until the beginning of the basketball season as claimant planned to try out for the regular high school's basketball team. Claimant felt he may be better able to transition once he has "a connection to some of his peers on the

basketball team." Claimant's parents and the IEP team met on October 2, 2006, to discuss many options. The IEP team determined that the best option was for claimant to transition to the high school classroom at the specialty school and try out for the basketball team at the regular high school. Transition to the regular high school would be considered again towards the end of the first semester.

115. Currently, it was noted that claimant had "been very successful in his classroom" at the specialty school. He performed at or above grade level in all academic areas and was "intrinsically motivated to learn." He was complying with teacher directions, completed all tasks assigned to him, demonstrated strong organizational skills and maintained an assignment agenda. "In the area of social-emotional/behavioral skills, [claimant] has also been successful at [the specialty school]." He had made significant gains in the area of peer interactions, established solid connections with his peers, taken a leadership role in the classroom, continually provided academic support to peers who struggled, and answered questions and commented during classroom discussions without prompting, "frequently using 'I' statements." More recently, as transition to the regular school was attempted, claimant's teacher at the specialty school noticed claimant "withdrawing more and appearing more depressed," although he continued to do well academically. He reported feelings of isolation at the regular school and was more reserved at the specialty school. Teachers at the regular school reported that claimant's work was "of excellent quality," and when called on participate, he did so appropriately and answered questions correctly. Claimant's parents reported that his experiences at the regular high school "created a great deal of stress, anxiety, and depression, to the point that twice [claimant] experienced panic attacks and was unable to attend school."

116. A BASC-2 was completed by claimant, his parents, and one of his specialty school teachers. Claimant's report of his own feelings and self-perceptions placed him in the average range or better on all composites, except for placing himself in the low range for emotional symptoms, and in the high range for personal adjustment. Claimant's parents and teacher all rated him in the average range on externalizing problems. His parents rated him in the at-risk range for internalizing problems, while his teacher and claimant rated him in the average range. Claimant's parents rated him in the at-risk range for anxiety, while claimant and his teacher rated him in the average range. Claimant's father and teacher rated claimant in the at-risk range for depression, while claimant and his mother rated him in the average range for depression. On the behavioral symptoms index, which included scales of atypicality withdrawal and attention problems, claimant's father rated him in the clinically significant range, his mother rated him in the at-risk range, and his teacher rated him in the average range. Both parents placed him in the at-risk range for adaptive skills functioning, while his teacher rated him in the average range.

117. The report documented that all raters' indexes were in acceptable ranges, indicating none of them rated claimant in an excessively negative manner and each of their responses was consistent. The results represented an accurate assessment of claimant's social-emotional functioning. The difference in his parents' and his teacher's reporting indicated claimant demonstrated different behaviors in different settings, which had been consistently reported throughout claimant's schooling.

118. Overall, claimant's "social/emotional skills demonstrated in the school setting" had greatly improved since he began attending his specialty school. His teacher reported that he "is demonstrating average levels of all behaviors and skills, except depression." His parents continued to have concerns about his perceived low

levels of anxiety, withdrawal, inattention, and atypical behaviors, as well as his low levels of adaptability, leadership, and functional communication. Despite those concerns, claimant reported that he perceived himself as well-adjusted and functioning at an average or higher level in all areas assessed. However, his recent difficulties transitioning to a public high school suggest that he continues to need work on developing and utilizing coping strategies and social skills in large group and social settings. He has had very positive growth at his specialty school, and the focus should now be on transferring those skills into different settings.

119. The results of the Woodcock-Johnson Third Edition Tests of Cognitive Abilities administered to claimant on October 5, 2006, were also summarized in the report. Claimant completed all tasks and put forth good effort, persisting when tasks became more challenging and was willing to admit he did not know the answer when he could not complete a task. He responded well to correction and the results represented an accurate estimate of his current levels of functioning. The majority of claimant's skills measured fell in the average range. His short-term memory skills were in the very superior range and his long-term retrieval skills were in the low average range. Strategies to address those areas were listed.

120. The "Vocational Evaluation" documented claimant's goal to be a professional basketball player in the NBA. Although claimant did not report any other career interests, the examiner noted that because of the high-level competition in becoming a professional athlete, it would be appropriate for claimant to explore other options and careers related to athletics. Claimant should also be advised as to what activities and classes he would have to take to achieve his goal of being a professional athlete in the NBA.

121. A May 18, 2007, Evaluation Report noted that claimant continued to be eligible for special education services under the category of autism. During the 2006-2007 school year, transition attempts led to claimant becoming more depressed and having increased anxiety. In January 2007, he was reported to be "reestablishing a baseline, and was more comfortable again at home and at [the specialty school.]" His teachers were currently reporting "a much quieter student who is more difficult to engage and is experiencing significant absences, which are due to anxiety and mental health concerns reported by parents."

122. As of May 15, 2007, "[b]ased on discussions at IEP meetings with a team of qualified professionals," claimant seemed to have "a substantial increase in social and school anxiety which is expressed at home." Claimant reported "a preference to engage in a more routine, simplified academic environment and program with less social pressures."

123. The "Observation Evaluation" referenced January 26, 2007, meeting notes which documented claimant's progress since being back full-time in the specialty school. He was making academic gains and had been reading more. He was showing good progress towards his IEP objectives. He was making social connections at school and a closer connection with one student. He was also using dry humor with teachers and peers and the reports were quite positive academically and socially for claimant. His parents also reported him being happier at home and the consensus was that most of claimant's emotional upheavals, anxiety and stress were expressed at home. Claimant attempted to participate in his high school's basketball program but found it difficult to get to the early morning practice. He thought it would be "too much for him" to scrimmage or play when a crowd watched him. He did not enjoy going to the basketball class, and made the decision to discontinue. All this was a stressful time,

especially as changes in routine, scheduling, and settings are very difficult for him. However, claimant was enjoying working out at the YMCA, and reported feeling comfortable in that setting. The IEP team discussed ways to transition claimant to his regular high school in the future.

124. The "Present Level of Educational Performance" report noted the difficulties claimant had with the attempts to transition him to his local high school. Currently, while claimant was able to achieve at a high level in the general education curriculum, his social fears and anxiety continued to increase and prevented him from accessing the curriculum in a general education setting or at his specialty school. His parents also reported increased anxiety at home which led to his many recent absences. There were no concerns with claimant's cognitive or academic skills. It was recommended that a more simplified, routine program with less social pressures be provided to claimant.

125. A May 18, 2007, "Secondary Transition" report noted claimant's interest in being a professional basketball player as mentioned during his 2006 evaluation. He had expressed an interest in pursuing a career in a field related to sports/athletics. He would need specially designed instruction to attend community college and it was suggested he contact his community college's disability services department to "look into available accommodations and correspondence courses offered by the college." The "Transition Goals" were that by May 18, 2008, claimant would have identified "jobs of interest improving vocational skills" from a list of careers given to him.

Claimant's Document Regarding His Public Speaking Career

126. During his evaluations, claimant described how he began publicly speaking to organizations after high school, as more fully detailed below. An undated

document illustrated claimant's public speaking career, summarized the topics claimant speaks about, his recent presentations and major keynotes, including national and international presentations, his work experience, his publications, including books and poetry, his awards, his fees, and contained testaments from others and links to more information.

WRC's 2023 Psychosocial Assessment

127. Jennifer Morales, WRC's Intake Counselor, performed a Psychosocial Assessment via Zoom in 2023 when claimant was 32 years old. Claimant was referred to WRC because he was suspected of having ASD. The primary purpose of the evaluation was to ascertain claimant's eligibility for regional center services. Claimant "actively participated in the intake process by providing pertinent information about his background and current functioning." Ms. Morales obtained additional information "from visual observations and interactions with" claimant.

128. Ms. Morales took a birth history, noting claimant was born via an emergency C-section and placed in the neonatal intensive care unit "for a couple of days." His early motor milestone trajectory was delayed and he was delayed in speech. Claimant dropped out of public school "since the 5th grade," attended online schooling, and received his GED in 2009. He took a college course online for one semester when he was 20 years old. He had started a part-time job six months ago at a yoga studio, working one or two days per week.

129. Claimant had functional use of his upper and lower extremities, his mother did not express any concerns, and none were observed. Claimant said others like how "kind, innocent, sincere and humble he is." Ms. Morales noted that claimant "presented as a kind and open individual."

130. During the interview, claimant did well and engaged with Ms. Morales. He had moved to Los Angeles on his own "about 1.5 years ago" after living with his mother for 31 years and realizing "he needed to venture on his own." He and his mother have a very close relationship. He has some friends but reported having "a hard time maintaining close and deep relationships." He "finds managing relationships exhausting." He sometimes volunteers for the Autism Society of America. He "desires to be part of a peer group but finds it difficult to do so."

131. Claimant reported he was dating a woman but reported sometimes having episodes where he shuts down and does not want to leave the house. "He feels like it is a sensory overload and he cannot think straight. He will not shower for days and sleep all day." Claimant reported not being an affectionate person and being told he "does not come across as a loving person." He stated that "he often feels misunderstood when it comes to showing affection." He reported sometimes getting "frustrated at his disability. He feels that he gets an ASD burnout which doesn't allow him to do his routine." He further reported being unable to function when he gets an "ASD burnout," getting "pseudo seizures where he starts twitching and can't do anything," and he has a history of severe panic attacks.

132. Claimant expressed his needs and wants with full sentences and made "seldom eye contact." His speech was understandable and his conversations were coherent. No cognitive concerns were noted. Claimant could perform activities of daily living but was unable to manage his medical bills or apply for insurance. There was no family history of developmental disability. Claimant's general health status was stable. Claimant reported concerns with sleeping too much and struggling with borderline anorexia. "He starves himself as a coping mechanism." Claimant worked and provided for his living expenses.

133. Ms. Torres's clinical impression included findings that claimant's developmental milestones were delayed, his health status was stable, and his medical history was unremarkable. She recommended referral for a psychological evaluation to rule out autism and/or intellectual disability and obtaining claimant's medical and school records.

Claimant's 2023 Psychological Evaluation

134. Miguel Rodriguez-Cortes, Psy.D, a registered psychological associate, supervised by Gabrielle du Verglas, Ph.D., a licensed clinical psychologist, performed a psychological evaluation of claimant on April 7, 2023, (review of records and clinical interview), April 17, 2023, (cognitive and adaptive behavior assessment), May 16, 2023 (social emotional assessment), and May 23, 2023, (parent interview and review of background history), on a referral by WRC. The report of this evaluation was signed by both Dr. Rodriguez-Cortes and Dr. du Verglas. The beginning of the report contained the following disclaimer written in bold: "The present evaluation was limited to assessment of developmental disability and is not a comprehensive mental health evaluation."

135. No information regarding the educational backgrounds or experiences of Dr. Rodriguez-Cortes and Dr. du Verglas was introduced.

136. Claimant attended all four appointments independently. During a full clinical interview, claimant provided information regarding his background history, which included his early academic, familial, and behavioral history, and his current concerns. His mother provided early developmental history information and additional information was obtained through records.

137. Claimant had self-referred himself to WRC because he was diagnosed with autism at 12 years old and recently moved to Los Angeles from Nevada to live independently. He expressed concerns regarding his ability to live independently and was seeking services through WRC to obtain the supports he needed "to lead a self-directed life and fully participate in his community." He reported suffering from "autistic burnout" that "leads to severe fatigue, overstimulation, and periods of not leaving his home for several days." He also reported experiencing intrusive thoughts that increase when he does not exercise.

138. Dr. Rodriguez-Cortes took a developmental history, a medical/psychiatric history (which was quite lengthy), a substance abuse history, a family/social history, a legal/forensic history, an education/employment history, and reviewed previous testing performed. Dr. Rodriguez-Cortes also administered several tests and performed a behavioral observation.

139. Claimant reported being diagnosed with an immune disorder, but could not recall the name. He also reported having non-epileptic seizures but was not being followed by a neurologist at this time. His last seizure was two years earlier.

140. Claimant is followed by a psychiatrist every two weeks. He is prescribed Klonopin (a benzodiazepine used to treat seizure disorders and panic disorder), Zoloft (an antidepressant used to treat various mental health conditions including depression, anxiety disorders and OCD), clomipramine (a tricyclic antidepressant used to treat OCD) and Lamictal (an anticonvulsant used to treat epilepsy and bipolar disorder). Claimant is "very strict with his medication routine" and "adheres to his medication regimen." He reported being diagnosed with autism, OCD, depression, anxiety and Post-Traumatic Stress Disorder (PTSD). He also had a "history of anorexia" but was not formally diagnosed.

141. Claimant reported "he is not observing a therapeutic diet" and being rigid with his food intake due to wanting to ensure he eats a healthy and "clean" diet. He primarily eats at home, rarely going to restaurants because of his difficulty being around groups of people. He reported that when he was younger, he did not like certain food items touching on his plate and only preferred to eat with a spoon.

142. Claimant's mother reported claimant was diagnosed with arthritis in adolescence and "had several surgeries to address loss of cartilage and other toe injuries." She reported claimant had an extensive history of mental health concerns and psychiatric hospitalizations, first being seen by a developmental specialist when he was six years old. At that time, he was "displaying a significant amount of school refusal and emotional outbursts."

143. Claimant's mom reported that claimant's pediatrician diagnosed him with ADHD due to claimant "being unresponsive to social engagement and being unwilling to answer the questions the doctor posed to him during his evaluation." Claimant was prescribed medication to address his inattention. His refusal to go to school did not improve with medication, and he began to display significant anxiety with panic attacks that impacted his overall functioning.

144. Claimant's mother reported he was then seen by a psychiatrist who raised concerns for a possible OCD diagnosis given claimant's behaviors. However, the psychiatrist did not diagnose OCD, but instead diagnosed claimant with anxiety. Shortly after that diagnosis, claimant was admitted to a psychiatric facility in March 2003 when he was 12 years old due to severe anxiety, panic attacks, intrusive thoughts, and self-harm ideation. His symptoms did not improve with his anxiety medication and worsened over time. Claimant's mother stated that the physicians at the hospital advised her that claimant had the "most severe case" of anxiety they had ever

observed, and claimant began experiencing extreme paranoia and hallucinations during his inpatient stay. The physicians discussed a possible psychotic disorder such as schizophrenia, but the records at discharge after his five-week inpatient stay indicated diagnoses of OCD and separation anxiety disorder.

145. After he was discharged on March 7, 2003, claimant's pediatrician reviewed the hospital records and advised that claimant's behavior and history of speech delays was consistent with a possible Asperger's diagnosis. Claimant was then referred to the Autism Center at the University of Washington for a comprehensive evaluation. Claimant's mother reported that claimant was then given an Asperger's diagnosis which the family believed "fit very well" as it provided clarity on claimant's symptoms.

146. Claimant's mother reported that although the Asperger's diagnosis gave clarity, claimant's behavioral and emotional challenges continued. He has been hospitalized several times in his adult life due to passive suicidal ideation and feelings of severe overwhelm which he described as "weird breakdown/meltdowns." Claimant has reported having sensory overwhelm during these meltdowns and also experiencing hallucinations.

147. Claimant reported he was hospitalized at 21 years old due to severe symptoms of OCD and anorexia. He also reported being hospitalized at 27 years old due to "passive suicidal ideation, severe overwhelm, and panic attacks." Claimant denied any current feelings of homicidal or suicidal ideation or behaviors. Claimant reported "medically using cannabis" to help him cope with sensory concerns and feelings of anxiety. Claimant also reported having issues with his father and his sister while growing up, "they were 'vicious' and 'emotionally abusive'" to him. Claimant described his family dynamic as "horrendous"

148. Claimant had received an IEP at age 12 after being diagnosed with Asperger's and he received speech and language services. Claimant's mother described how claimant would spend his day sleeping in the counselor's office, not participating in the classroom, but was able to get "A" grades. Claimant and his mother described the difficulties claimant had in school, eventually being placed in a school that specialized in autism and "making great strides there." Claimant's mother reported that he "outgrew" this specialized school and transferred to public school for his last two years of high school. He struggled with this transition and had behavioral challenges. He agreed to give his new school a try, but things worsened when claimant did not make his high school basketball team, ultimately leading him to enroll in a continuation school and getting his GED when the family moved to Nevada.

149. The report documented that claimant "is an independent individual who lives alone in his own apartment. He rents a guesthouse in Los Angeles." Claimant had moved to Los Angeles "about 1.5 years ago." He lived with his mother for the past 31 years and "realized that he needed to venture out on his own." Claimant reported having a very close relationship with his mother and talking to her on a weekly basis. He reported "having a hard time adjusting to adult independent life" and "will call his mother for comfort and guidance."

150. Socially, claimant reported he does not have many friends as he struggles to engage socially with others and develop close and meaningful relationships. He reported always being a "social outcast," and that he prefers to engage in solitary activities "although he strives and wants to develop friendships." He has had several romantic partners in the past whom he met through dating sites. He has difficulty engaging with others due to his difficulties leaving his home and he tends to cancel or reschedule plans.

151. Claimant reported he works as a receptionist for a yoga studio, provides for his living expenses, and receives medical care through Medi-Cal. Claimant also reported working as a public speaker for several mental health organizations which he has been doing for several years. He does approximately 14 presentations per year. He obtained this speaking job because he is a "go-getter" and "often pursues what he wants by contacting people via email." He mentioned having "two personalities," one being an "imaginary business partner" who helps arrange his travel plans and makes bookings for his public speaking events. Claimant arranges his own schedule so as to reduce stress.

152. Claimant also authored two books related to his ASD experience and is the co-chair of the Autism Society of America's Safety Task Force. He reported that his job as a public speaker is fulfilling and does not significantly make his symptoms worse. While his fear of crowd noise is overwhelming, when on stage he manages by using several coping skills he has developed over time. He reported his job as a yoga receptionist worsens his anxiety symptoms as he feels confused how to manage social relationships at work. He has often had to cancel or reschedule work meetings or plans in order to manage his symptoms of overwhelm and burnout.

153. Claimant's mother reported claimant "is very astute with money and can manage his money without much support from her." She helped claimant obtain Supplemental Security Income (SSI) benefits which he has had since he was 16 years old. Claimant reported he met the Disabled Adult Child eligibility category. (Other documents indicated claimant advised he was receiving Social Security Disability Insurance (SSDI) benefits; this was not explained at hearing.)

154. Dr. Rodriguez-Cortes reviewed the discharge summary from claimant's 2003 hospitalization. The document noted claimant was hospitalized for five weeks

and discharged on March 7, 2003, with diagnoses of OCD and separation anxiety. His symptoms began during third grade and he had been followed by a psychiatrist on an outpatient basis prior to his hospitalization. He took medication and was in therapy. He was hospitalized "due to the severity of his symptoms." His symptoms of "checking, counting and needing to touch other things and an irrational fear of bugs" lessened but his "intense anger and obsessive thoughts continued, and a protocol for addressing thoughts of self-harm was developed." Dr. Rodriguez-Cortes noted that only the discharge summary was provided, not "the initial diagnostic assessment records."

155. In addition to a records review, clinical interview, and behavioral observation, Dr. Rodriguez-Cortes also administered several tests. He noted that claimant established eye contact, shook hands, and said hello. In the office, claimant engaged in a brief conversation about his day and mentioned needing to finish the appointment on time as he had an appointment shortly afterwards. Claimant "displayed well-modulated eye contact with use of gestures and vocalizations when engaging with" Dr. Rodriguez-Cortes.

156. After conversing for a few minutes, claimant directed his attention to the testing instructions as the first test began. Claimant "was responsive to all testing tasks and displayed appropriate motivation and effort." He completed the test in a reasonable amount of time and transitioned well during testing tasks. Given claimant's efforts observed during testing, the test results were considered a valid representation of claimant's current functioning.

157. During testing, claimant "spoke in full sentences without speech difficulties. He often made repetitive clicking noises with his mouth before speaking or providing any verbal responses. He did not spontaneously engage in interactions with

[Dr. Rodriguez-Cortes] and did not attempt to engage in conversation." Claimant did not initiate or respond to humor, and "maintained a rigid behavioral stance with a flat facial expression throughout the evaluation."

158. Dr. Rodriguez-Cortes noted further during his behavioral observation that:

> During his second testing appointment, [claimant] participated in an assessment of his ability to engage in conversation, and with back-and-forth interchanges about his emotions and social difficulties. [Claimant] reported difficulty feeling comfortable in social situations and noted needing to muster a lot of strength to be able to engage socially with others. He expressed feeling nervous in social situations given his difficulties appropriately reading social cues and initiating and developing social relationships. He was able to engage in reciprocal conversation with [Dr. Rodriguez-Cortes] but struggled with initiating exchanges or sustaining conversations beyond answering questions. [Claimant] reported on his long history of conflict in the home and became emotional when speaking about his family history. He also reported on the history of his social difficulties and the impact such challenges have had on his overall mental health. He reported on his feelings of depression and anxiety, and how these relate to his lack of social success and difficulty "fitting in." Throughout his engagement with [Dr. Rodriguez-Cortes], [claimant]

> displayed flexible thinking, good ability to engage in perspective taking, and moderate insight into his social difficulties and relationships with others. He also displayed adequate emotional awareness and conversational turn-taking skills.

159. Dr. Rodriguez-Cortes administered the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV), a standardized measure of intellectual abilities. Claimant's scores on the verbal comprehension index, perceptual reasoning index, working memory Index, and processing speed index were all in the average range. His full-scale IQ score also fell in the average range. Claimant's scores showed he had strength in working memory abilities, suggesting a "strong ability to sustain attention and focus as well as understand and retain new information. He may be able to effectively manage and perform complex tasks that involve multiple steps or components." Claimant's scores on other tests revealed he "has adequate abilities in understanding and using language, thinking and problem-solving, and processing visual information quickly."

160. Dr. Rodriguez-Cortes administered the Wide Range Achievement Test-Fifth Edition (WRAT-5), a test to examine an individual's skills in word reading, sentence comprehension, and math computation. Claimant's word reading and sentence comprehension scores were in the above average range, and his spelling scores were in the average range.

161. Claimant provided the information obtained on the Adaptive Behavior Assessment System-Third Edition (ABAS-3), a behavior-rating format to identify adaptive skills strengths and difficulties. His scores in the general adaptive composite and conceptual composite scores were below average, and his social composite score was low. The below average range scores suggested claimant's overall adaptive

functioning is below what is typically expected for individuals his age, which may have implications for various aspects of claimant's daily life and functioning, and may require support.

162. Dr. Rodriguez-Cortes administered the Autism Diagnostic Interview-Revised (ADI-R), an instrument designed to assess for behaviors associated with autism. Claimant's mother served as the informant for this assessment. Her responses were consistent with an autism classification. But, Dr. du Verglas and Dr. Rodriquez-Cortes stated in their report that "it is important to note final diagnostic and treatment decisions regarding autism should be made with confirming information from independent sources."

163. On the Beck Depression Inventory, Second Edition (BDI-II), given to assess claimant's current level of depression, claimant scored a 14, indicating mild depression. He endorsed feeling sad much of the time, getting very little pleasure from the things he used to enjoy, feeling restless or wound up more than usual, being less interested in other people or things than before, finding it more difficult to make decisions than usual, feeling loss of energy, being more irritable than usual, having trouble concentrating, and becoming tired or fatigued more easily than usual.

164. The "Impressions" section noted that claimant was diagnosed with OCD and separation anxiety disorder in 2003 at age 12, following a five-week inpatient hospitalization. That "inpatient hospitalization did not diagnose [autism] and upon recommendation of his pediatrician he was referred for a diagnostic assessment at the University of Washington Autism Clinic, with diagnosis of Asperger Syndrome rendered." Claimant attempted to obtain the University of Washington records but was unsuccessful as those records are no longer available.

165. While the results of the ADI-R interview with claimant's mother "endorsed symptoms frequently occurring in an [autism] diagnosis such as social difficulties, especially in groups, with preference for individual interactions, with early history of sensory over reactivity to textures of clothing, buttons, and sound sensitivity," those "positive [autism] symptoms, however, need to be viewed in the context of other comorbid psychiatric diagnoses of depression, [OCD], and eating disorder, with reported episodes of hallucinations and thoughts of self-harm resulting in multiple psychiatric hospitalizations in adulthood." The "Impressions" section stated further:

> The [autism] symptoms are difficult to parse out from the comorbid symptoms of psychiatric disorders. Therefore, the [autism] diagnosis will be rendered on a provisional basis based on historical diagnoses of Asperger disorder, coded at Level 1, requiring support, in light of average cognitive abilities and ADI-R symptoms, based on mother's report, barely meeting criteria in domains and abnormalities in reciprocal social interaction (score 10, cut off score 10) and in abnormalities in communication (score 8, cut off score 8).
>
> Currently, [claimant] does not show any language delays, is engaged in public speaking, and is a published author. Despite many challenges, he currently lives independently, has a driver's license, and moved from Nevada to California independently without assistance from his mother. He obtained his own housing and part-time employment, manages his own finances, and completes household

> management tasks independently. Ongoing issues with being overwhelmed and social difficulties continue, resulting in inability to leave his apartment for several days due to sensory overload, which [claimant] refers to as "autistic burnout."
>
> Per the DSM-5, an [autism] diagnosis requires persistent impairment in reciprocal social communication and social interaction (Criterion A) and restricted, repetitive patterns of behavior, interests and activities (Criterion B). The symptoms need to be present from early childhood (Criterion C) and impair functioning (Criterion D). Claimant met the ASD criteria "by history with overlap of OCD symptoms."

166. Dr. du Verglas's/Dr. Rodriguez-Cortes's report further documented that claimant "will be rendered the diagnosis of provisional [autism] without language impairment and without accompanying intellectual impairment (Level 1 in social interaction and communication and Level 1 in restrictive and repetitive patterns of behavior)." Claimant's "social communication and rigid patterns of behavior are long-lasting, dating back to early childhood and were recognized when he was" diagnosed with Asperger's Syndrome at age 12 by the University of Washington Autism Clinic. "[F]urther comprehensive psychodiagnostic evaluation is necessary to rule out other potential psychiatric disorders that can best explain [claimant's] current symptoms and thus guide accurate treatment and support planning."

167. The report noted that claimant had a historical diagnosis of OCD and separation anxiety disorder and that the conditions to be ruled out were: sensory

processing disorder, social anxiety/panic attacks, persistent depressive disorder/dysthymia, eating disorders (anorexia), and PTSD.

168. The report contained several recommendations, including having claimant undergo "further comprehensive psychodiagnostic evaluation[s] to rule out other potential psychiatric disorders that can best explain [claimant's] current symptoms and thus guide accurate treatment and support planing," and an occupational therapy evaluation to rule out a possible sensory processing disorder. In bold, the report also contained a disclaimer indicating that the examiners were not making any decisions about eligibility for regional center services as that was a decision the eligibility review team made, and that a diagnosis alone was not sufficient for regional center eligibility.

169. Dr. du Verglas and Dr. Rodriguez-Cortes recommended claimant undergo genetic testing, participate in a comprehensive psychodiagnostic psychiatric evaluation, have an occupational therapy evaluation, undergo a vocational assessment and vocational training, access mental health services, and have a rheumatology evaluation, noting that arthritis "can significantly affect one's daily life and overall well-being . . . can have significant impacts on mental health . . . can contribute to emotional distress and depression" and "may also trigger anxiety, stress, and feelings of overwhelm." Dr. du Verglas and Dr. Rodriguez-Cortes also recommended claimant have a neurology re-evaluation given his history of non-epileptic seizures.

2025 Psychological Evaluation by Dr. Cronin and Dr. Freeman

DR. CRONIN'S AND DR. FREEMAN'S CURRICULUM VITAES

170. Claimant's attorney referred him to Pegeen Cronin, Ph.D., and B. J. Freeman, Ph.D., who performed a psychological evaluation of claimant in January 2025, and authored a report.

171. Dr. Cronin's curriculum vitae (CV) indicated she received her Bachelor of Arts in psychology from University California, Berkeley in 1987. She has been a licensed psychologist since 1998. She received her Master of Science in clinical psychology in 1992, and her Doctor of Philosophy in clinical psychology in 1995, both from Palo Alto University. From 2003 to 2012 she worked at the UCLA Center for Autism Research and Treatment, where she doing research with Dr. Freeman from 2007 to 2011. She was the Assistant Director and then the Clinical Director at UCLA's Autism Evaluation Clinic until 2012. Since 2013, she has been in private practice. Her CV documented her community service, editorial service, research experience, and her professional associations. Dr. Cronin has given ADOS and ADOS-2 trainings since 2003 to regional centers, school districts, and medical centers, and is "recognized by the ADOS-2 publisher as a trainer for the ADOS-2." (ADOS-2 refers to the second edition of the ADOS which occurred in 2012.) Dr. Cronin further explained her education and experience during her testimony.

172. Dr. Freeman's CV documented that she received her Bachelor of Arts degree in 1966 from Mercer University in Georgia. She received her Master of Art degree in 1968, and her Ph.D. in 1969, both from Southern Illinois University. She has been a licensed psychologist in California since 1976. Her CV listed her professional training and experience, the lectures and presentations she has given, her publications,

the honors she has received, her community service, her professional society memberships, the numerous professional advisory boards on which she has served, and legal matters in which she has been involved. Her CV documented her extensive experience in the autism field. Dr. Freeman further expounded on her education and experience during her testimony.

DR. CRONIN'S AND DR. FREEMAN'S REPORT

173. Dr. Cronin conducted a diagnostic interview with claimant on January 15, 2025. Dr. Freeman conducted a follow-up telehealth interview with claimant on January 18, 2025, and a developmental history telehealth interview with claimant's mother on January 17, 2025. The tests administered to claimant were: Subtests from the Social Language Development Test, Adolescent Normative to claimant; the ABAS-3 to claimant's mother; and the Behavior Rating Inventory of Executive Functioning, Adult (BRIEF-A) to both claimant and his mother.

174. At the time of their assessments, claimant was 34 years old. He had been referred by Disability Rights California as part of its appeal of WRC's eligibility determination. The report noted that due to the delay in claimant's autism diagnosis and vulnerabilities associated with autism, claimant was experiencing increased anxiety and depression.

175. Dr. Cronin and Dr. Freeman noted that claimant had moved to Los Angeles from Nevada "a little over three years ago with the hope of gaining greater independence and establishing social relationships. However, his [autism] continues to substantially disable [him], so he not demonstrated gains in his social life or independent adaptive abilities," nor gained "insight that changing his location" does

not "result in self-improvement or diminish prior challenges across social and occupational settings."

176. The findings from their evaluation "concur with prior diagnostic impressions that [claimant] presents with [autism] that substantially disables him and recommends WRC eligibility." The report stated that the evaluation performed by Dr. Rodriguez-Cortes and Dr. du Verglas and WRC's intake procedures "were not adequate to determine eligibility and did not conform to best practice guidelines (Department of Developmental Services (DDS), 2002)." Further they found no support for claimant's prior diagnosis of OCD, instead noting that claimant "has a myriad of repetitive thoughts and behaviors that are ego syntonic (one's thoughts and behaviors align with one's self-image) and as such they do not cause psychic distress that causes his substantial disability. These repetitive thoughts and behaviors result from his [autism] and have substantially interfered with his ability to fulfill his potential from the time he was young." The report noted that claimant's developmental history, behaviors and symptoms were best characterized by the DSM-5-TR diagnosis of autism and that claimant demonstrates substantial disability in the areas of self-care, learning, self-direction, communication, economic self-sufficiency, and capacity for independent living.

177. The report's "Summary of Interview" noted that claimant initially lived in one area of Los Angeles and three months ago moved to a larger apartment in a different area. He chose to move to Los Angeles from Reno because he had not experienced independence and Reno was too small. He did not have friends in Reno and "during the pandemic realized the only person he knew was his mother." Today, he continues to struggle to establish reciprocal social relationships and now has one friend of a few months, whom he sees a couple times a month at her home nearby. He

walks there and they may have a meal and watch a movie. "As he discussed his dismay and disappointment at not having friends, he complained that people were unavailable because they 'worked,' and he did not demonstrate insight that it is typical that social relationships must accommodate one another's occupational and social commitments."

178. Claimant also reported challenges organizing around the sensory environment and that transitions were always difficult. His transitions seemed most difficult across his routines. When he "travels to speak in a different place he easily adapts more or less, but still struggles and may have 'meltdowns,' prolong transitions, and have difficulties with adaptation."

179. The "Occupational History" section of the report documented that when claimant was in his mid-20s, he started to investigate opportunities for public speaking about autism. "Currently, he does not seek opportunities, but rather is contacted to speak at conferences targeted for topics about disabilities." He has presented at a variety of conferences on his journey, struggles and successes, speaking at "a handful a year." He "tries to bring more awareness of [autism] and the challenges experienced that result in mental health issues." He briefly worked as a receptionist at a yoga studio, "technically he is still employed," but he has not worked for over a year. He struggled at the yoga studio because of "the dense social environment," and while he "saw it as an avenue to socialize and make friends, he observed that others demonstrated social ease during interactions that was not possible for him." During 2016 to 2017 he worked as a "paraprofessional at a school in Nevada for students who have autism," but was "'forced to resign because of burnout.'"

180. The "Daily Schedule" in the report noted that claimant's daily routine tends to include daily exercise, and that he is at his best during the first four hours of

the day. He will also write, read, and listen to a podcast, after which he will go to the gym. If he does not go to the gym his "day is shot." The issues that prevent him from going to the gym may include fatigue, organizing difficulties, and environmental factors. He "tends to have very black-and-white thinking," and "struggles with persistent inertia, fatigue, and anxiety." Claimant restricts his caloric intake and in the past was "obsessed" with counting calories. He described his sleep patterns and the medications he takes that are prescribed by his psychiatrist at University of California, Los Angeles (UCLA). The medications are clomipramine, Zoloft, Lamictal, and Klonopin which "tamp down his symptoms, they do not remit his symptoms."

181. The "Behavior Observation" section of the report documented claimant's flat affect and that he "did not demonstrate a range of facial expressions or coordinated gaze." He would list his experiences and symptoms with specific details but at other times would speak in generalizations, not provide a response, or use more language than was needed for a response. He "became tearful towards the end of the session when discussing social adaptation and interaction," and his speech "tended to be overly formal."

182. The "Diagnostic Interview" documented that claimant "recognized that he tends to be more comfortable by himself but then he also is isolated." He said he was "killing myself" with his desire to be more independent. He continues struggling with organization, reported inconsistent hygiene maintenance, may run out of groceries, and has trouble persisting in tasks, such as cleaning. He finds leaving his house "extremely difficult." He got the job at the yoga studio after he "'brainstormed for quite a few weeks' to determine what would 'align,' and proceeded with it in part because of his interest in Eastern medicine." He does not know what type of job he would like to have and "'never had the opportunity to discover what he wanted to be,'

demonstrating a lack of insight." However, he later described being "all about growth," and spending money on "uncomfortable experiences" to learn about himself. He described various careers he wanted to pursue and how public speaking "still leaves him isolated."

183. Claimant described establishing some relationships but that "people were infrequently available." He is the one who has to initiate but often does not because others are busy. Between 2023 and 2024, he lost many friends who either moved away or stopped communicating with him. He described the one friend he may see every couple of weeks when he goes to her house. Claimant has not had difficulties getting along with others but he is "irritated that he is not as socially adept as his peers." He has been told by others that he is "incredibly easy to get along with," yet at times he may be too sarcastic. He described the benefits of living on his own, including the freedom it provides, and it gives him "a 'blank canvas to try to create something in my personal life.'" He also described the difficulties of living on his own and how he missed his mother.

184. Claimant's scores on the Social Language Development Test, Adolescent: Normative Update (2017), a diagnostic measure of social language skills for adolescents ages 12 to 17, was administered because it "also provides information to better understand [claimant's] social perceptions and language-based interactions. Claimant's age equivalency on the subtests measuring "making inferences" was at 12 years six months old; his age equivalency at the subtests measuring "interpreting social language" was at 14 years old. These results indicated that claimant's abilities were "poor for recognizing social expressions and responding to them," yet he had "a foundation of knowledge for some social rules and practices." During the testing, claimant "struggled a great deal to interpret the facial expression and provide

responses." He gave inconsistent responses on the interpreting social language subtest.

185. The BRIEF-A, a standardized measure that captures views of an adult's executive functions or self-regulation in the adult's everyday environment, was completed by both claimant and his mother. The results showed that both claimant and his mother recognized claimant's "significant disabilities to plan, organize, track and sequence tasks." Claimant "also has significant difficulty in his ability to inhibit impulsive responses, adjust to changes in routine or task demands, modulate his emotions, initiate activities or problem-solving strategies, planning organized problem-solving approaches, and monitor his own behavior."

186. The report summarized Dr. Freeman's two-hour telephone interview with claimant's mother conducted prior to administering the ABAS-3. Claimant's mother described her years of struggles attempting to get assistance for claimant. She reported becoming concerned when claimant was two years old because he was not talking even though his hearing was normal. At age three when he went to daycare, he sat at his cubbyhole and stayed there all day. He then went to a different daycare and participated a little bit but that teacher suggested he be assessed. He was seen by a developmental pediatrician and claimant's parents were told claimant was not delayed.

187. Claimant was seen by another developmental specialist at six years old because he would not talk to anyone but his mother, and "[a]gain, he remained undiagnosed." Claimant did well in kindergarten and made two friends who were classmates but was "devastated" when that family moved away. Claimant missed a lot of school in first through third grades, would become overwhelmed, and had panic attacks. Claimant's third-grade teacher reportedly told claimant's mother that she did not understand him. Claimant began fourth grade, but then became "very upset easily"

and refused to go to school. Claimant's fifth grade teacher also expressed concerns about claimant's behavior, advising the claimant "had a number of rituals and behaviors."

188. At age 12 claimant was admitted to the University of Washington hospital where he remained for five weeks and was diagnosed with anxiety and OCD. At this point, claimant's pediatrician suggested claimant's behavior may be due to autism, so he was seen at the Autism Clinic at the University of Washington where an autism diagnosis was made. With that diagnosis, claimant's mother was able to get an IEP at school but claimant continued to have problems and refused to attend school. "He ultimately went to a special school for a year and then completed a GED."

189. Claimant's mother reported that claimant has never had a steady job other than at a school for autistic children but he was let go because he "became so stressed out." Another attempt to work resulted panic attacks. When claimant lived with his parents, he was not working. He recently had a job at a yoga studio but that also did not work out, and claimant has not worked for over a year. The report noted that a further developmental history was provided in Dr. du Verglas's report.

190. The scores on the ABAS-3, completed by claimant's mother, indicated that claimant's "functioning measures less than one percentile in most areas. This is inconsistent with his normal IQ, and as a result of his [autism] he demonstrates an inability to apply acquired skills to the natural environment." The report stated: it "should be noted that [claimant's] mother reported a more significant level of disability currently than [claimant] did on a self-report from [Dr. du Verglas's] report, indicating that [claimant] does not demonstrates [*sic*] insight for his current life situation."

191. The report referenced the ABAS-3 manual which advised that assessors should examine the validity of self-reports and that Dr. du Verglas's evaluation was not completed by individuals who knew the daily adaptive behaviors of the person being assessed. The ABAS-3 manual further notes: "As with all of the data collected during the assessment process, [the evaluator] is responsible for verifying the validity of the information provided by self-rating." Dr. Cronin and Dr. Freeman opined that the evaluation for eligibility conducted by Dr. Rodriguez-Cortes, and Dr. du Verglas "does not conform to this standard."

192. Based on claimant's mother's responses, claimant's scores were extremely low in the conceptual, social, and practical areas with some subtests in those areas being in the average and low ranges, and his general adaptive composite was extremely low.

193. The report contained Dr. Freeman's behavioral observations/interview with claimant. When asked how he is able to live and pay bills since he was not working, claimant advised he does not spend money, is extremely frugal, and pays his rent with his SSDI check and his savings, with his mother reporting that claimant had savings from the time he worked as an aide in the school. Claimant's mother continues to pay claimant's car insurance and any service repair costs. Although claimant reported trying to be independent after leaving school, he was unable to describe what he meant by this.

194. Claimant reported being extremely frustrated because he had no friends. He has been seen by multiple psychiatrists over the years. He tried doing an online community college course but was unable to complete it because he became too overwhelmed. Although he signed up to participate in groups with adults with autism, he had difficulty relating and became overwhelmed. He described the one friend he

currently had, but is alone 90 percent of the time. Although he takes medication, he has never had a "positive response" to it. He sees "someone for 'talk therapy," but feels it is not helping him."

195. Claimant thought he applied for regional center services two years ago after learning about it at one of his speaking engagements. When asked about the services he hopes to receive from regional center, claimant indicated he wanted to receive "'psychoanalysis and get to the root cause of all my issues.'" Dr. Freeman wrote that this is not the goal of a regional center, as its goal is to provide services to help claimant learn to be independent and provide direct teaching of skills. Claimant's mother was "eager for her son to receive" those supports. Dr. Freeman noted that her interview was consistent with Dr. Cronin's interview.

196. Claimant and his mother were administered the Social Responsiveness Scale (SRS-2) (Adult Form - Parent and Self-Report), an assessment which identifies social impairments associated with autism and quantifies the severity of autism symptoms as they occur in natural social settings. Although there were some significant differences between claimant's and his mother's report, results from both of them indicated claimant demonstrates clinically significant deficits in reciprocal social behavior that interferes with his daily social interactions consistent with an autism diagnosis with at least a moderate severity.

197. In their "Summary," Dr. Cronin and Dr. Freeman reported that claimant presents with autism and a significant history of delays in adaptive functioning through development, including social isolation. They opined that claimant's plan to relocate to Los Angeles leaving everything familiar thinking he would promote his socialization was "like someone who is blind thinking they can use a non-Braille paper map to direct them. It is impossible and dangerous." The diagnostic interview and

direct evaluation of claimant's social communication also indicated his social communication disabilities and delays result from his autism diagnosis.

198. Claimant had never received consistent, diagnostic specific interventions for his diagnosis, further disabling him. Based on claimant's autism diagnosis, and his extremely low adaptive function, he "functions more like a child." He has demonstrated responsiveness and motivation to engage in intervention and treatment to learn about autism, how it impacts him, and how to improve his social communication and independent adaptation. The report noted that claimant meets the DSM-5-TR criteria for autism requiring substantial support for social communication and social interaction, and restricted, repetitive behaviors; without intellectual impairment; and with language impairment (pragmatics and social language). They ruled out a major depressive disorder.

199. Specifically, they found that claimant met the autism criteria because he had persistent deficits in social communication and social interaction across multiple contexts currently and by history because he had deficits in social-emotional reciprocity, deficits in nonverbal communicative behaviors used for social interaction, and deficits in developing, maintaining and understanding relationships (Criterion A). They found that the severity of his deficits was Level 3, requiring very substantial support, due to his severe deficits in verbal and nonverbal social communication skills that cause severe impairment in functioning, and his very limited initiation of social interactions and minimal response to social overtures from others.

200. They found claimant had restricted repetitive patterns of behavior, interests or activities both currently and by history (Criterion B). He had stereotyped or repetitive motor movements, use of objects or speech, an insistence on sameness, and flexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior,

had highly restricted, fixated interests that were abnormal in intensity or focus, and had hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. They determined these restrictions were a Level 3, requiring very substantial support, due to claimant's inflexibility of behavior, extreme difficulty coping with change or his other restricted/repetitive behaviors that markedly interfere with his functioning in all spheres, and his great distress or difficulty changing focus or action.

201. Dr. Cronin and Dr. Freeman addressed the Lanterman Act's substantial disability requirement, finding that claimant's "social adaptive skills are significantly below what would be predicted from his cognitive skills." Due to claimant's autism and "lack of intervention over the years, he presents with substantial disability across multiple life skill areas and adaptive functioning." Further, he "does not appear to have a realistic view of his adaptive skills in the natural environment." Dr. Cronin and Dr. Freeman found that in the area of receptive and expressive language, although claimant has developed language and was quite fluent, he had significant deficits in the pragmatics of language and difficulty initiating and carrying on conversations. He interrupts, and perseverates on topics of interest. He loses his train of thought and frequently goes off on tangents. His language is very disorganized. He does not respond to verbal or nonverbal cues. He does not use gestures or facial expressions in communicating with people.

202. In the area of learning, Dr. Cronin and Dr. Freeman found that claimant has demonstrated the ability to learn rote academic tasks and has an excellent memory and a wealth of information, but shows significant impairment in adaptive skills and ability to apply his knowledge and skills to new situations in real life. He is a self-starter, but only for learning things he feels are important and his perseveration hinders his ability to learn to function independently in a variety of situations. He has a

great deal of difficulty with executive functioning skills and becomes overwhelmed by large assignments with difficulty staying on task. His ability to apply cognitive skills to his own life is significantly lacking particularly when new tasks are presented.

203. In the area of self-care, they found claimant was self-sufficient and competent for basic self-help skills but often does not engage in his routine for hygiene and self-care activities and required prompts when he lived with his mother. He has days he is unable to follow his routine to care for himself and his home, and is unable to go into the community. He runs out of groceries, and at times does not know what to do. He is unable to plan meals per week, shop for necessary items, and then prepare food.

204. Dr. Cronin and Dr. Freeman opined that the area self-direction was claimant's primary issue because "he shows significant impairment in the ability to make and apply appropriate personal and social judgments and decisions he makes." His current problems are a direct result of his difficulty making appropriate choices and decisions. He is unable to plan, organize, and initiate tasks unless they are directly related to his own perseveration. He does not want to be around people who disagree with them. He does not understand how his behavior affects others or that others might think differently. These difficulties distort his understanding and ability to comprehend and react to others. This deficit makes it impossible for him to understand things he considers irrelevant.

205. As to claimant's capacity for independent living and economic self-sufficiency, Dr. Cronin and Dr. Freeman opined that he has demonstrated over the past few years that he is unable to live independently and sufficiently provide for himself. His capacity for independent living is extremely limited. He has not shown the ability to perform everyday activities in a way that minimizes his reliance on others. He has

not developed age-appropriate independent living skills including performing household tasks, money management, and budgeting. He manages his own affairs in an inappropriate manner and, realistically, will require a great deal of support to develop appropriate living skills in the future. He has had several jobs, none currently, saves his money and does not spend it. He has a large savings account that supports him currently but it is not clear that he has a plan for when his savings run out. He has been unable to maintain a job for more than several months. His difficulties with executive functioning skills significantly impact his ability to maintain appropriate attention to tasks and to what is relevant in the environment. He lacks the capacity to obtain and maintain employment without significant support.

206. Given claimant's autism diagnosis which caused his substantial handicaps, Dr. Cronin and Dr. Freeman opined that claimant was eligible for regional center services, and made several recommendations in their report.

Dr. Cronin and Dr. Freeman's March 2025 Supplemental Report

207. Dr. Cronin and Dr. Freeman authored a supplemental report on March 8, 2025. They reviewed WRC documents (an intake form and the 2023 psychological report), WRC's denial letter, school records from Washington state, University of Washington Autism Center records, and "miscellaneous treatment records." Claimant had been referred to them by Disability Rights California as part of his appeal.

208. Dr. Cronin and Dr. Freeman noted that WRC denied claimant's request for eligibility because, although WRC acknowledged his autism diagnosis, it concluded he did not present with substantial disability in three or more specific areas as required. Dr. Freeman and Dr. Cronin opined that based on their assessment,

claimant's autism diagnosis caused substantial disabilities in six of the seven specific life skill areas required. They also identified several issues with the 2023 report.

209. They wrote that the "2023 report did not evaluate and address whether or not [claimant] has a substantial disability including substantial disabilities resulting from his [autism] diagnosis." Although that report evaluated claimant's cognitive functioning and autism diagnosis, it did not address his social adaptive skills or the areas of disability required by law. They opined: "In order to assess substantial disability, the standard of practice is to utilize a measure of social adaptive behavior completed by someone who knows the person extremely well (such as a parent, sibling or caregiver)." They noted that it is well-documented in the literature that individuals with autism "do not have an accurate picture of their own skills and are generally unable to evaluate their own abilities and disabilities."

210. Although claimant was administered the ABAS-3 in 2023, and his mother was interviewed in detail, she was not administered the ABAS-3 or any adaptive functioning measures. They again referenced the ABAS-3 manual which stated it should be completed by those who know the individual's daily adaptive behaviors and that the assessor should verify the validity of the information provided in a self-rating. They opined that "the 2023 report did not provide any collaborative evidence to support [claimant's] assessment of his own adaptive skills."

211. They noted further that even though his skills were not corroborated, claimant still scored himself as below average in all areas, particularly the social area. They further opined that it "would have been necessary to follow-up on whether or not [claimant] really is able to completely take care of himself and live independently." Dr. Cronin and Dr. Freeman also referenced the DDS 2002 Best Practices which

requires the assessment of social functioning be collected from multiple sources, noting the vital information parents can provide.

212. They also opined that the 2023 report provided no collateral information to support Dr. du Verglas's/Dr. Rodriguez-Cortes's impressions that claimant did not have language delays, was engaged in public speaking, was a published author, lived independently, relocated independently without assistance, obtained housing and employment, managed his own finances independently, and completed household management tasks. They opined that prior records and their own 2025 evaluation identified that this was "not representative of how [claimant] functions." They noted he was no longer employed, and that while he drives a car and lives in an apartment, he is supported by his mother in a number of areas which were addressed in their 2025 report.

213. They also opined that although the 2023 report gave claimant a provisional diagnosis of autism, the DSM-5-TR states that "historical information is sufficient to make a diagnosis in adults when there is no history for an interval of age-appropriate social adaptation." Further, the 2023 report did not adequately address the OCD diagnosis because it did not delineate the symptoms of OCD and explain why claimant would meet those criteria and not autism criteria. In addition, although claimant's psychiatric difficulties and hospitalizations were reviewed in the 2023 report, "little attention was given to [claimant's] in-depth evaluation at the Autism Center at the University of Washington (2003) and his school assessments that systematically documented his diagnosis and resulting substantial disabilities."

214. Dr. Cronin and Dr. Freeman further noted that the amount of time each professional spent with claimant was not reported in the 2023 report. Although Dr. du Verglas "has a great deal of experience working with persons on the autism spectrum,"

Dr. Rodriguez-Cortes's training and experience were not known. Further, the 2023 report did not review and address all the areas of substantial disability and describe claimant's behavior in each area. As such, that report cannot determine "one way or another" if claimant has substantial disability in any of the required areas. In contrast, their 2025 report did address how claimant's autism diagnosis substantially disables him, and it was "concerning" WRC relied on the 2023 report.

2025 Evaluation by Dr. Dubner and Dr. Prater

215. A Multidisciplinary Psychological Assessment was performed for WRC on May 28, 2025, to determine claimant's eligibility for regional center services. The report was signed by Rebecca Dubner, Ph.D., a licensed psychologist, and Kristen Prater, Psy.D., a registered psychological associate. Dr. Prater performed the assessment under Dr. Dubner's supervision. The evaluation was "limited to an assessment of [claimant's] quality of functioning based on his diagnosis of autism." The evaluation was "not a comprehensive psychodiagnostics evaluation of mental or emotional disorders or conditions."

216. Information regarding Dr. Dubner's and Dr. Prater's education and experience was not introduced.

217. Dr. Prater interviewed claimant, and administered tests to him and his mother. She reviewed Dr. Rodriguez-Cortes's 2023 psychological evaluation, including the results of testing he administered, and claimant's 2004 IEP. Dr. Prater also reviewed records from "Autism Spectrum Disorders – Coordinated Care Clinic, Melvin Morse, M.D., Spring 2003" which noted that claimant "presents with a diagnosis of Asperger's syndrome, specifically with difficulties in sensory processing, emotional reactivity, sedentary muscle and body tone, and distractibility and inattentive presentation."

Claimant's diagnosis "impacted his education. A request for an educational evaluation was presented, including occupational therapy." Claimant's "sensory sensitivities directly effect [*sic*] his ability to process the sensory information within his educational environment."

218. Dr. Prater performed behavioral observations and took a history of claimant's background and education, home and adaptive life, social life, work experience and economic self-sufficiency, and repetitive and sensory behaviors. Her history was consistent with other records introduced at hearing.

219. Dr. Prater assessed claimant's affective/behavioral functioning by administering the Childhood Autism Rating Scale, Second Edition (CARS-2), a behavior rating scale used to identify children with autism, which she completed through her observations and interactions with claimant. Claimant's scores were in the age-appropriate and mildly impaired ranges, and Dr. Prater opined that claimant's raw scores fell in the minimal to no symptoms of autism range.

220. Dr. Prater administered the ADOS-2 Module 4, which she wrote was one of four modules in the ADOS, specifically designed for verbally fluent adolescents and adults. It assesses social interaction, communication and play or imaginative use of materials through a standardized set of activities and observations.

221. On the ADOS-2 Module 4 in the area of language and communication, claimant spontaneously generated phrase speech of three to five words per utterance and generally used appropriate variability in intonation, reasonable volume, and normal rate of speech. His use of words and phrases tend to be more formal than most individuals, but he did not express odd expressive behaviors and occasionally offered information spontaneously about his own thoughts, feelings, or experiences.

He provided reasonable accounts of his routine and "his conversation flowed, building on [Dr. Prater's] dialogue."

222. On the ADOS-2 Module 4 in the area reciprocal social interaction, claimant displayed appropriate eye contact and expressed a range of facial expressions to communicate, displaying a variety that reflected his emotions. He showed insight into several typical social relationships, but not necessarily into his role. He described himself as being responsible for his actions, displayed "a slightly unusual quality in some of his social interactions," displayed "some responsiveness to most social contacts, but his interactions were consistently negative."

223. Claimant did not show excessive or unusually sensory interests "in play materials or people," did not display hand, finger, or other complex mannerisms, and did not display compulsions or rituals. He occasionally referenced usual or highly specific topics or patterns of interest. His ADOS-2 scores did not meet the cut-off for autism.

224. On the ABAS-3 Parent/Caregiver Rating Form, which was completed by claimant's mother, claimant's scores were in the extremely low range. Areas of concern were communication, community use, home living, health and safety, leisure, self-care, self-direction, socialization, and work, with the scores in communication, leisure, social, and work indicating marked difficulties.

225. In her "Summary and Diagnostic Considerations," Dr. Prater noted that claimant's mother's scores on the ABAS-3 were not consistent with claimant's clinical presentation. For example, contrary to the mother's scores, claimant participated fluidly in conversations with Dr. Prater, has maintained a friendship with an ex-girlfriend indicating he can navigate changes in relationship status, and has

maintained his personal business of advocacy and public speaking for over five years. Additionally, the drastic change in the scores obtained currently and those obtained in 2023 suggest the current scores may be unreliable.

226. Dr. Dubner and Dr. Prater opined that based on claimant's current evaluation, including his ADOS-2 and CARS-2 scores, claimant "appeared to manage his symptoms of [autism] well." Further, "these scores confirm" Dr. du Verglas's/Dr. Rodriguez-Cortes's 2023 diagnosis of [autism] level 1, "in both social communication and repetitive and restrictive behaviors."

227. Dr. Dubner/Dr. Prater wrote:

> A level 1 diagnosis in the area of social communication is given when the individual presents with social deficits in social communication which causes noticeable impairments. A level 1 diagnosis is appropriate when an individual has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses. [Claimant] shared that he has decreased interest in social interactions. A level 1 diagnosis in the area of repetitive and restrictive behaviors is given when these behaviors cause significant interference with functioning in one or more contexts. Additionally, when someone resists attempts by others to interrupt these behaviors. According to DSM-5, [autism] is a lifelong disorder that changes over time as expectations of life change and develop. At this time, it appears that [claimant] is managing his symptoms of

[autism] well. [Claimant] should continue to monitor his symptoms.

228. Dr. Dubner/Dr. Prater wrote that regional center eligibility considers both the diagnosis and the areas of substantial disability set by ARCA,[1] an individual must have three or more areas of substantial disability. The report then reviewed those areas, noting that in the area of self-care, claimant has deficits in personal hygiene, only showering once weekly, but is able to dress independently, and feed himself safely. In the area receptive and expressive language, claimant "demonstrated his skills in restrictive language appropriately, understanding [Dr. Prater's] communication" and "did not require further explanation of words or questions." Claimant's expressive language appeared to be age-appropriate. He engaged fluidly in conversation and did not display odd tonality or cadence in his speech. In the area of learning, claimant's previous psychological report evidenced average general intelligence ability and his academic performance fell in the average range. He did not display difficulties in the areas of reasoning or retention. His math and reading skills were in the above average and average ranges.

229. In the area of mobility, claimant demonstrated average skills. In the area of self-direction, claimant shared that he has significant difficulties maintaining relationships with new friends and his family members, and difficulties when changes in his routine occur with maladaptive behaviors as a result. In the area of capacity for independent living, he has the ability to grocery shop and complete basic living skills. At times, his self-direction interferes with these tasks, but he lives independently and

[1] These areas are found in the Lanterman Act and the applicable regulations.

manages his own feeding habits. He uses a phone to call his mother, friends, and potential work opportunities. He understands basic safety around the house and in the community, and is able to obtain his own prescriptions from the pharmacy. In the area of economic self-sufficiency, he has a source of income which he independently sought after and built a business for himself. He travels independently for work, following a schedule and sourcing transportation. He is often contacted by agencies for work, which demonstrates his success as a public speaker and advocate.

230. Dr. Dubner/Dr. Prater's diagnostic impression was that claimant had autism without intellectual impairment or language impairment, provisional given based on a historical diagnosis of Asperger Syndrome; Level 1 in social communication and interaction, requiring support; and Level 1 in repetitive restrictive activities, requiring support. Claimant also had historical diagnoses of OCD and separation anxiety disorder.

Video of Dr. Prater's Assessment

231. Claimant introduced the videotape of Dr. Prater's assessment of claimant. Dr. Gayles observed that assessment from another location, describing herself as a "fly on wall" for it. Dr. Dubner's/Dr. Prater's report documented that Thompson Kelly, Ph.D., Mayra Mendez McDermott, Ph.D., and Dr. Ari Zeldin, M.D. also observed Dr. Prater's interview. Claimant asserted that the videotape demonstrated that Dr. Prater failed to perform an adequate or appropriate evaluation.

232. During the assessment, Dr. Prater was seated at a table with her laptop in front of her and documents to her right which she referred to during the assessment, turning the pages. Claimant was seated across from Dr. Prater, and his mother was seated in a chair behind him against the wall with a clipboard in her hand that held a

document she can be seen filling out. Audio recorded the interactions between the three individuals. The angle of the video was behind and above Dr. Prater's right side such that her laptop screen is in view, although what is on the screen is not clear. Once seated, claimant looked at the camera and around the room.

233. During the assessment, Dr. Prater asked questions and sometimes typed on her laptop as claimant was answering her questions; at other times she watched him as he spoke. Claimant answered questions posed to him appropriately, using appropriate gestures while answering and making intermittent eye contact, and is even seen smiling during an interaction. Claimant also asked appropriate follow-up and clarifying questions and stayed on topic. He did not use any inappropriate gestures or demonstrate any restricted or repetitive behaviors. Claimant appeared able to easily communicate and engage in conversation with Dr. Prater, and establish a rapport with her.

234. Claimant used an extensive vocabulary while speaking, giving wide-ranging descriptions of his thoughts and actions. He described things he "loves to do," but said he does not do them. He does not have any leisure activities because he does not know what to do if given free time. He loves to learn but described his reading as "more like a ritual." His books "are heavy, brainy" as he "is very philosophical, very intellectual." He reads to "recharge and rejuvenate."

235. While speaking, claimant demonstrated an excellent understanding and insight into his abilities and limitations, as well as his likes and dislikes, even describing himself as "existential." He noted he has been "very isolated throughout the majority" of his life. He has "observed society on the sidelines" and "through that I garnered a lot of curiosity about the world and why society has so many barriers to the world for people like me." He enjoys "deep thinking to shift my perspective and gain more

insight" and he "prides [himself] on giving [himself] knowledge." Claimant differentiated between "intellectually" knowing things versus "emotionally" feeling them.

236. Claimant described his personal relationships as "tough." He sees his best friend, a woman, about once a month which is "not enough for me." He described the "convoluted" relationship he has with her because they "used to casually date" in the past; "it's not really a typical friendship." Claimant also has one guy friend that is a "very new" friendship.

237. He has been "putting a lot more effort" in 2025 trying to "break through my own defense mechanisms." He has never had a guy friend, his last guy friend was when he was 12 years old. He has spent his life "being by my mom's side." He has "a lot of fears" bringing new people into his life. He has "a lot of defense mechanisms" and "a fear of intimacy."

238. The new male friend claimant recently made he has been "trying to prioritize more." They meet for coffee, "but it's not really fun, it's fulfilling, but not really fun." He has another friendship with one woman. Claimant used the air quotes gesture when describing this latter friendship and then commented as to why he had done so, specifically using the term "air quotes" in his explanation.

239. Claimant described his "very rigid" routines, especially working out. He does not like his routines but trying to change them "is playing with fire," which he describes as trying to play with a Jenga tower (a game where players try and remove pieces of a tower from the stack without knocking over the tower). If he tried to change parts of his routine "it could stand, it could fall apart." He described the "heavy burden" he wakes up with every morning of having to exercise. If he does not exercise,

"it is really hard for me to function the rest of the day." There are also days he cannot go to the gym because he is "overstimulated."

240. Claimant was asked to explain his statement that getting coffee with his guy friend was "stimulating" and "fulfilling" but "not fun." He said there were "many things I would like to do in life." He then explained that he and his friend discuss "very heavy stuff," "very similar to reading," "so it takes a lot of mental energy." Claimant would love to have a guy friend with whom he "could just go grab a drink and talk about sports."

241. Claimant guessed that he "hasn't discovered what fun is yet." He has had "such a limited social engagement with other people," and then commented how he does not even know if he would like going to a bar and hanging out with the guys. He would like to try a lot of things that he does not have access to right now. He does "not know the whys and why nots." He "gets stuck." His routine "imprisons me," "it cages me." He described his routine being like a train station; if he misses one station, it feels like the train left without him. It feels like "the wires are not connected." He spends almost every evening inside, even though he does not want to do so. He wants to do certain things, but there is "a disconnect I guess."

242. Claimant described the difficulties he has traveling given his rigid routines. It "is not conducive to how my brain works." He explained how his "brain knows" when he is in a new place for work so cannot adhere to his rigid routines and how "liberating" that is for him. Travelling is escaping his routine but is also "a double-edged sword" because he cannot do his routine. He can discuss his struggles on stage which helps as he "cannot fake it til I make it."

243. When asked how he created his public speaking career, claimant explained he never worked, never went to college, was in his mid-twenties, was "very lonely, very depressed," "felt useless, left behind by the world." "But I know I had a lot of insight to give" and could reflect on his experiences. He "never got a lot of external validation from society" so he "wanted to be seen and wanted to be heard." He "can excel at the extraordinary but really struggles with the simple. So it is very easy for me to do public speaking but is very nerve-wracking to do one-on-one dialogue, or small talk, or talk to a cashier at the grocery store." He uses "my struggles as motivation."

244. Claimant thought public speaking would "help me move forward in life and also help others." He started his career by "cold calling" and reaching out by emails to autism organizations in Reno. He was "basically very blunt" and exchanged emails with organizations for nine months. He was asked to speak at a gala, met someone who encouraged him to apply to the governor's council, and it grew from there. His business is by "word of mouth." He did all the work to create his website, he had "to figure it out on my own." He does between zero and three talks per month but is "underemployed" and would like to work more. If he "is feeling balanced" when he wakes up, he will work for a few hours on the computer, sending emails, and doing other tasks. He will then have "one of those disconnects in the afternoon" where he would like to do more work but cannot.

245. Claimant said he is paid for his speaking engagements and can sustain himself and his bills with that income, as well as with his SSI disability income.

246. He will ask the organization what topic they would like him to speak about, and will do research and then speak on that topic. He "is in a state of flow" when he walks on stage. He does not use notes, he uses a power point to prompt him but then expands on those topics.

247. Claimant told Dr. Prater that grocery shopping is "a big struggle" and he runs out of food. He does not like using a delivery service because he likes his produce a certain way and does not like others touching his food. He will purchase dry oats and live on those when his food runs out.

248. Claimant noted that these are "dark days" and others do not understand how he is able to do some tasks but not others. He described how people in his past "have really chewed me out" for "not trying hard enough" and how he "internalized that." Now when he cannot grocery shop, "I don't tear myself apart. It's like internalization. I know I'm not worthless, but I feel worthless. Intellectually I know I love myself, but inside it's very difficult." He described how it may take a few days to be able to grocery shop and that when he can, "it's a huge accomplishment for me."

249. Claimant described his personal hygiene and laundry routines. He will re-wear gym clothes if he did not sweat too much. He will do laundry depending on the weather, as he will sweat more when it is warmer, and acknowledged he should probably do laundry more, but it is "part of that disconnect." He showers after working out. If he does not work out "it is very difficult for me to shower that day." If he goes a few days without working out, it is "a big struggle" for him to shower. He uses the same dishes for about a week, he will rinse them out and reuse them, so it is minimal dishwashing.

250. Claimant described household tasks that were and were not priorities for him, admitting he would like to keep a cleaner house, but the gym and groceries are his priorities, which he described as his "two anchors."

251. At 28:16 of the video, Dr. Prater turned in her chair, reached behind, pulled out a book, and placed it on the table in front of claimant. She told him she is

going to ask him to tell her a story based on the pictures in the book and he asked her appropriate clarifying questions. At 28:40, when claimant first looked at the picture, Dr. Prater checked the documents next to her and then went on her laptop.

252. Claimant begins by describing the "turtle on a log in a swamp" he observes, who "has an expression on his face," but "is not a human," and that if it were a human, "maybe they were surprised by something, but I doubt that is what the turtle is thinking." At 28:48, Dr. Prater's laptop screen changes and what appears to be a text thread appears. Dr. Prater types while claimant is describing what he sees and several times she readjusts her laptop and screen, in what looks like attempts to prevent claimant from seeing what she is typing.

253. Dr. Prater than turns the page of the book and points out other animals and objects in the picture, and says the turtle is wondering what those fish are doing. Claimant asks, "Why are they floating, is it like a magic thing?" and Dr. Prater shrugs. Claimant then states that "the turtle is pretty freaked out" and "it doesn't make much sense they are there" but "there are a lot of subliminal meanings behind there" that claimant cannot convey "without any context," and he shrugs and asks if he was supposed to look at the title of the book.

254. Dr. Prater turns the book page again, asking claimant to describe what he sees and that "then we can move on." Claimant points out the pictures on the two pages. Dr. Prater asks if he sees anything funny on the page and claimant says, "Not to me, not, but to a child, yeah." When asked, he says a child might find "the face on the frog" funny, but "it irritates me for some reason." He then shrugs and says, "But the child could very well be freaked out by it, too, but who knows, it's a very strange book to me." At 31:32, Dr. Prater closes the book and puts it behind her desk, out of view.

255. When asked about "any social difficulties," claimant described a "disconnect" with people. He will encounter people, "want to see them again or cultivate a friendship," and even though he has "researched extensively," and he "moved to LA to try and create a personal life," which "I knew was going to be hard, I just didn't know it would be this d**n hard, I don't know what's going on, but obviously something is, cuz I am not connecting with people I want to connect with" despite his efforts.

256. When asked what annoys him, he said "the majority of strangers" as it is very hard for him to look at a stranger "and not get annoyed." He discussed going for a walk that day and there being too many people on the sidewalk. He feels people walk way too close to him despite him moving to the other side of the street. He described feeling "trapped" and knowing it was "not their intention," but he does not know how "to ease my discomfort." He described how people not walking in straight lines at the airport "infuriates me," getting "knocked into all the time," and "people's lack of awareness, that really keeps me up at night." He thinks this is why there is "a disconnect" when he tries to make friends.

257. Claimant was asked to explain his answers about "discord" in his life, to which he said. "there was a lot to unpack." He then talked about struggling his whole life, referenced a friend in preschool he wanted to befriend who was often talking in a group so he would not approach him, so he would "stay in my cubby" all day. He described being "very detached." This continued through elementary school despite being "taken to all the top doctors" because he "was obsessive" and "had a lot of rituals." He had a lot of thoughts, never told anybody about them, felt guilty for thinking them, but once he told his mother, they tried to get him "help for that."

258. However, "this wasn't the treatment I needed." He was "ultimately forced to drop out" of public school in fifth grade. He "finally got an autism diagnosis" when he was 12 years old, so he "finally got an IEP," but the "school refused to adhere to it," so they had fight with the school board "to get it adhered to."

259. Claimant talked about "being judged on my behavior a lot." He rarely made eye contact, he "was not able to speak like this by any means" (indicating how he was able to speak with Dr. Prater), he had "a severe, severe speech impediment" so "even if I had the courage to speak," he could not be understood. "So, a lot of teachers kind of looked at me like this kid who kept to himself and didn't want to be part of the environment when I was hoping someone would just come into my world," but it "never happened." He said, "Even when the IEP was, quote, unquote, implemented, it really wasn't." "It was surprise after surprise."

260. He then gave an example, saying, "like today, not knowing I was going to be observed live . . . I have autism and unexpected surprises are very difficult for me so I wish I had known that. It might not look like it, but inside it really shocks my system."

261. He described how other kids would make fun of him for being "that quiet kid in the corner of the room." He dropped out and did online classes and spent two years in "a specialty school which was somewhat beneficial. They were able to come into my world every now and then. But ultimately I tried to mainstream back into public middle school and high school about three times," but "there was a lack of sincerity and respect from the teachers acting like I was now this kid they had to deal with on top of everything else they have in the class. So it never worked out."

262. Claimant described how basketball was his "only love." He was "mainstreamed back into the public high school so he could try out for the basketball

team." There were "extensive meetings" with claimant's teachers and parents, discussing how claimant wanted to try out for the team and there was an agreement reached that claimant would at least be placed on the lowest level team "so I could have some compadre with other peers," but that did not occur.

263. Claimant was given the wrong time for tryouts and despite this being his "one opportunity in 18 years to be part of a collective," him getting ready, and his father driving him, the coach said the tryouts were cancelled and scheduled for the next day. However, claimant "was off my game, no pun intended, and they cut me" from the team. Claimant described this experience as being "heartbreaking" and began crying while speaking. As he begins to cry, Dr. Prater's laptop screen changes to what appears to be text messages.

264. Claimant then described it as being "so hard" and discussed getting "dismissed a lot." He described himself as being treated like that "over and over," how "they come in phases, they come in different ways, and they manifest differently now that I am a grown adult." He did not want to drop out of high school, he "had friends when I was 12," but "I did detach from them" because he missed three weeks of school due to bronchitis and he was "so afraid" to return to school because he feared his friends would ask where he had been, so he stopped talking to them "because of my anxiety." He was too afraid to talk to his friends, it "snowballed," and "was so overwhelming for me, I didn't have my diagnosis yet, that came six months later, and I just had to remove myself from all this ball of stress that was society."

265. Dr. Prater is then observed switching screens from the text messaging screen to the one that appears to be her notes of claimant's responses.

266. Claimant goes on to say that while removing himself helped, as he was not "suffering as much," he still had his "internal struggles but there was no societal friction on top of that, while that helped, I also lost the only bridge I had to society." He "tried three times just through school alone to try to build that bridge," he tried "the basketball way to try to build a bridge," and he tried "community groups that were not my cup of tea, unfortunately." "I always tried to build a bridge but nobody built the d**n bridge over to me. I was on some island. I have always had to swim over to the mainland. So I was left on an island for 20 years." He "used to be part of the mainland, and then I struggled and people sort of relegated me to an island."

267. Claimant agreed he kept trying, but was met with roadblocks and still continues to meet roadblocks. "Thankfully" he was "able to use it and transmute it into passion and use all my frustration and pain to really be passionate when I talk on stage because I don't want anyone to go through this and I know a lot of people do."

268. Claimant admitted to having intrusive and sexual thoughts, which "morph," the biggest of which are "eating and the gym." If he misses the gym he immediately thinks his "body is going to change instantaneously." He described how having his mother with him the past 24 hours made him realize how many thoughts he has that he has no one to whom he can express them. Instead, he deals with the "guilt" of those thoughts, and gave as an example how he loves to eat mangoes all the time and feels guilty doing so. Voicing his thoughts to his mother made him realize they are not normal.

269. Claimant has "a big phobia of food. It's an obsession, but it's also a familiarity, a rigidity, if you will, with my autism." He described his limited food choices and acknowledged how counting calories "took over his life" in the past, and he is "not paying attention" but cannot eat the way he would like to eat. He discussed body

dysmorphia with his psychologist. When he was 23, he was going to be sent to a hospital in Wisconsin. It "got so bad," and he "was in a severe depressive state." He did not change his clothes for two months. It was the closest he had ever come to "just retiring essentially." He was "too depressed to go to the gym" and "really started restricting" what he ate. He never had a problem with food before that time. "It was out of the blue" which is "typically how my obsessive and intrusive thoughts come."

270. One day while sitting on the couch after not having changed clothes for two months, he realized his hair was falling out when he "was supposed to be in the prime of my life." He "wanted to experience my college years and wanting to self-discover and here I was sitting at home with my hair falling out, but they denied me at" the Wisconsin hospital; insurance denied it "so I never got treatment for it."

271. Claimant's mother was then asked about this and said she could not really remember as they have had "so may struggles and so many barriers to getting treatment and help." She did not recall how they dealt with the food issue, but knew they had "an intervention team through the state [Nevada] come to the house." Claimant's mother said the plan was for claimant to continue seeing his psychiatrist and therapist and continue taking his medications. Claimant corrected Dr. Prater when she said he was seeing his psychiatrist weekly, telling her it was monthly and his therapist was seen weekly.

272. Claimant has been on psychiatric medications "for about 25 years." When Dr. Prater asked him to identify his medications he asked if she also wanted the dosages and then gave both to her, as well as when he takes them, identifying all four medications he takes as Klonopin, Lamictal, clomipramine, and Zoloft.

273. As to his other intrusive thoughts, now they are "like a sword in my stomach, mostly all sexual." He does not talk about them with anybody and did not want to share them with Dr. Prater. He wishes he could as "I hate keeping them on the inside." At this point claimant's mother asked if he wants her to leave the room so he can tell Dr. Prater about them, but he declines.

274. Claimant has "always had" intrusive thoughts that "have really ramped up" now that he is "independent." His therapist just retired, he was not given a referral, so he had to search online for a new one. While talking, claimant became choked up, leaned back in his chair, and placed his hands over his eyes. His new therapist "talks 80 percent of the time" and he "does not know what to do with that," so he does not know what will happen and agreed it is hard finding the right therapist. He described what he does to keep his intrusive thoughts "in check," including working out. His "only supports really are medication support and sound avoidment, but actually solutions I am going to try and figure out."

275. Claimant explained his rituals are ways to keep his thoughts "in check." But "the more graphic sexual" thoughts are a "very visceral reaction" where he feels like his "insides are being lit on fire, and literally it feels like the essence of viscerally triggered and I just have to swallow it because if I chase it and try to even tell myself a different story about it because if I even take a step in that narrative, it swallows me whole so I have to try, but it is so tempting to figure out (a) why am I getting the intrusive thought or (b) provide context that that's not true but if I do that it will suck me in so I just have to go like this" at which point claimant began open-handedly beating on his upper chest area demonstrating what he does. However. "it is hard" especially as he lives alone and has "very little stimuli."

276. Claimant does not currently have ritualized behaviors. In the past, he counted or focused on various sights, but "grew out of that." He will speak out loud to someone, asking questions he answers. He described a "huge" issue that was troubling for the family where his OCD made him "have to have one" of the potato chips his sister was eating, and she refused, which caused him to have a meltdown and led to "a shouting match with the entire family."

277. Claimant wore his hood "24/7 as a child." He does so now at the gym or at home. He does it as "insulation from stimulation." It is a "buffer." He will also rock back and forth when he gets "sensory overload." He is a nail biter and nail picker. When little, he always needed to have a ball in his hand to grip.

278. When asked if he can differentiate between his autism and his OCD, claimant said, "My autism is the core of my brain, it's how my brain operates and my OCD is like the program installed on the brain. So my OCD is exacerbated from the rigidity of my internal mechanisms" and "they kind of feed off each other." If he "takes OCD out of the picture, I still have a h**l of a lot of rigidity. I need to know what's coming." He "thinks in pictures." It is hard for him to enter an environment where he does not know what it is going to look like. His best friend (the casual dating friend) is the only one he can confide in about how his mind works. He will "paint a picture in his head" of how he thinks a place he is going to is going to look, even if he has no idea how that place looks. He needs "something tangible" for him "to latch onto," "otherwise if it's total ambiguity I don't know what to do. I need something tangible even if it's a false tangible." However, when the place looks different, he has to repaint it in the moment while he is processing it.

279. Dr. Prater next asked for a moment to organize her thoughts and appears to be typing her notes and then reads from the papers on her desk.

280. Claimant denied ever having experiences that made him feel cheerful. The mornings are "the best part of my day" for 30 minutes after waking. He is "somewhat dormant," although he may get a "workout high" from a good workout. He has "never known what happiness is." Things are now "a little less uncomfortable" than when he was younger, but it is really just "suppression." "There is nothing uplifting about my life."

281. Claimant gets angry at society in general, "at the lack of decency and sincerity in the world." He "has a lot of bones to pick with society." He "used to be fearful nonstop." He had "severe phobias" of bugs, spaces, people, and "any external stimuli outside of his home." He recalled fearing he was stepping on slugs with every step he took on walks. He would break down and could barely leave the house. Now, "the fear is more existential." He is still afraid of people, and people walking too close to him on the sidewalk. He is "afraid of living in a world that is really not built for people like me." His "functioning mechanism runs on a state of agitation."

282. Claimant noted, "I don't have an environment. If I want to be part of this outside world, I have to accommodate society. I don't have a place where this world accommodates me."

283. At this point, claimant's mother interjected and mentioned his "airport situations" with people having to call the police, when he was having a meltdown. Claimant said he "has had the police called many times." He then described incidents at airports where he had meltdowns, and referenced a time when his flight was cancelled. He went to a quiet area to calm down to prevent a meltdown, and explained he needed a quiet area to rebook his flight and was overstimulated. Ultimately, he sat in the quiet area of the lounge in the check-in area, and just curled into a ball, and had a meltdown. The manager then came over and advised claimant that unless he left,

police would be called. He told the manager he has autism and was having a meltdown, and "needed a quiet space to decompress and rejuvenate out of this meltdown to regulate my nervous system but people just don't believe me." Claimant then reported having difficulty making others understand or appreciate that he has autism, saying he needs to get it tattooed on his forehead or he wear a sign. Airport management was going to call police, but, "thankfully," another employee intervened whose nephew has autism, who helped claimant breathe and police were not called. He calmed down but was sweating.

284. There are times when he knows going to the gym will decrease his stress, but he does "not know the variables," so he just stays in. He used to work out at home when he was a teenager, but does not do so now.

285. At 1:07, Dr. Prater tells claimant she has two questions left for him and then asks him what his plans and hopes for the future are. Seeking clarification, claimant responds, "Is that both the questions or is that one question?" Dr. Prater replies it is one question. During this exchange, Dr. Prater's screen shows what appears to be red and gray boxes which look like areas for the topics to be discussed and areas where Dr. Prater would enter claimant's responses and/or her observations.

286. After asking the question about his future plans, claimant sits back in his chair, looks down, and pauses while contemplating his answer. Dr. Prater is seen typing on the screen with the red and gray boxes.

287. At 1:07.09, Dr. Prater's screen changes and blue and gray boxes appear. Dr. Prater is seen typing and appears to be communicating back and forth with someone as her screen shows two different color boxes that are the types that appear when individuals message back and forth, with the color boxes differentiating one

person's message from another's. Dr. Prater's message at 1:07.09 appears to be a continuation of a previous exchange.

288. At 1:07.46, claimant looks up and tearfully replies to the question about his future plans, stating he would like to be "[unintelligible] in my personal life." His answer is unintelligible because he is crying.

289. At 1:07.48, Dr. Prater switches back to the screen with the gray and red boxes seen previously and appears to be inputting claimant's answer.

290. Claimant next states he would like to date, not "be sitting at home every night," "just, I guess, your typical normal life if you will." Claimant was crying as he spoke, shrugging his shoulders as he gave the last answer. He is "trying so hard." He would "like to get that taste of happiness. Feeling alive and not just existing." He would like to "feel grateful for the day, not just that I got through the day."

291. Claimant has "a lot of fulfillment in his life because I can use my suffering to help others." But, "fulfillment is one thing," "I have very little, again, I really don't know what happiness is." He is "definitely not content." He would like a "more well-rounded life." "Ideally, I would have liked to have been married by now," or "at least have one single date with somebody." He would like to have a child by his 40's. He would like more structure by working in an office, meeting people through his co-workers.

292. While claimant was talking, Dr. Prater's screen at 1:08.54 switches from the red and gray boxes back to the screen with the blue and gray boxes and she is seen typing. At one point she stops typing, folds her hands together in a prayer-like pose, and looks at claimant while he is speaking. At 1:09.16 Dr. Prater switches her screen back to the one with the red and gray boxes.

293. Claimant's dreams "are to spread more awareness of what I call my type of autism." He feels "there is so much monolithic thinking when it comes to autism; you can't be attractive, you can't function at high level things, that I can do that leads people to think, 'Are you really autistic?'" He has met people like himself.

294. When Dr. Prater praises him for his accomplishments, he asks her, "Yeah, but at the same time, what good is an accomplishment because I am struggling a lot more?" His "well-being is deteriorating."

295. His "hopes and dreams" are "human connection." He wants to feel safe, which he rarely feels. He wants others "to accept me as I am" and he only has that with his mom and his best friend. He wants to feel like he belongs, which he rarely does. He feels like he has to force his way into things and he is "that weird guy." He does not "know how to initiate an invite to hang out with somebody," or if he does, they turn him down. He has to "try to live instead of living."

296. When asked what WRC can do for claimant, he acknowledged not knowing the "full extent" of all they provide, "but if I could snap my fingers," he would like to learn more about independent living skills and "strategies to overcome" when he gets "stuck and not having any executive functioning." "It would be great if someone could help me run groceries, run errands, because I can't even run errands."

297. Except for groceries, right now he has to wait to visit his mother to do his errands. He would like "someone to help me structure my day because my OC- my, my mind structures my day, I don't do it." (Of note, claimant began his answer by stating his OCD structures his day, but caught himself after saying "OC" and changed his answer to say "my mind.") He would like to change his routine but he does not know how, he is "locked into it."

298. Claimant would like to learn "more about the hidden rules" of how to connect with people "because I must be missing out on something."

299. Claimant's mother then stated that communication was an issue and that claimant's friendship expectations are different from others' expectations. Sometimes he has lost friendships because of miscommunication. Claimant has "a lot of trouble navigating" social communication.

300. Claimant would also like help with self-regulation, saying he has never been taught this skill and wants to do "something more than rocking back and forth." He has interests but is not able to execute them and turn them into hobbies.

301. There is a Buddhist temple near his home that has 10:00 a.m. Sunday services he has been trying to attend for the past eight months, but he has "not been able to get there." He would like someone to help him plan on how to get there or pick him up and take him there. He would like to know how others do this because he is "just doing this makeshift thing called life and it is falling apart quite often." Claimant's mother added that it takes all of claimant's "energy to do these things that other people just do automatically with ease."

302. Claimant would also like help self-advocating as he has "a really hard time" advocating for what he needs. He has a really hard time advocating with his psychiatrist and his new therapist. His mother "knows this like the back of her hand" because he always calls her and complains. He "always asks for help from these people but maybe I am not saying it strong enough. Maybe I'm too people-pleasing," but he does not know the reason, and is now hesitant to ask for help and feels "dismissed." "There is a huge minimalization of my struggles." Others do not "understand the gravity of my words when I say I am struggling." He is in a "black hole" and maybe

needs to advocate better for himself because the "whole line of being independent" is not going well.

303. Dr. Prater asks if there is anything else and claimant's mother responds that her "focus for him would be communication" and "one-on-one interaction." Claimant then says he needs help with making small talk. He "loses a lot of opportunities" because he lacks the skills to follow up and connect with others. He "gives off leave me alone vibes" because he does not know what to do. Perhaps he "dives too quickly into the deep stuff" and maybe overwhelms others, as opposed to making small talk.

Articles and Other Documents

304. Claimant introduced several articles regarding, among other topics, autism diagnosis, levels of support, autism severity as it relates to disability, and best practices for an autism diagnosis. As noted below, Dr. Cronin and Dr. Freeman referred to some of them during their testimony.

305. An undated "Final Statement of Reasons," which did not identify the author, described DDS's proposal to "revise regulations pertinent to the definition of substantial disability that is used to determine eligibility of individuals with developmental disabilities for regional center services." The document described the proposed amendments to regulations which conform to 2003 amendments to Welfare and Institutions Code section 4512, and the reasons for those proposals, including that the amendments to Section 4512 "conform to the definition of substantial developmental disability utilized by the federal government."

306. Social Security records verified the benefits given to claimant in 2024, and the information claimant's family provided in support of the request for Social

Security benefits. It was unclear when the family applied for these benefits, and only partial documents were introduced. In response to various questions, claimant's family advised that claimant has minor mechanical speech problems and difficulty with the practical use of language making it hard at times for him to express himself. Claimant also has difficulty learning in the classroom setting, difficulty with social contact, interacting with others, how he becomes distressed, worried and depressed, and that he must follow a rigid routine. His abilities "had deteriorated dramatically over the past 3-4 years," and claimant cannot be unsupervised.

307. A February 19, 2024, Social Security Administration Benefit Verification Letter set forth claimant's social security benefits and confirmed he became "disabled under [Social Security Benefits] rules" effective January 1, 2020. The "Type of Social Security Benefit Information" stated claimant was "entitled to monthly disability benefits." Claimant's qualifying diagnosis was not listed in the letter. The "Information About Supplemental Security Income Payments" section noted: "Payments were stopped beginning August 2014," and that Social Security found claimant "became disabled under our rules on June 1, 2009." Again, no information regarding claimant's disability was mentioned in the letter.

308. WRC interdisciplinary notes documented communications with claimant and events that took place in 2022 and 2023 regarding claimant's application, intake, and evaluations.

Witness Testimony

DR. GAYLES'S TESTIMONY

309. Dr. Gayles's testimony is summarized as follows: She is a WRC staff psychologist whose duties include performing psychological evaluations and assessing

individuals for regional center eligibility. She was part of the eligibility team that evaluated claimant and determined he was not eligible for regional center services. Dr. Gayles received a clinical forensic psychology degree and is a registered psychological assistant. She described the training she has received on the various tests and assessments referenced in claimant's records and/or administered to him, as well as her training and experience in making observations during assessments. Dr. Gayles has completed all the required hours for licensure and was scheduled in early 2026 to take her Examination for Professional Practice in Psychology (EPPP), the standardized psychology licensing exam. Since 2016, Dr. Gayles has performed over 100 psychological evaluations, 25 of those evaluations were since being employed by WRC.

310. Dr. Gayles testified about her work history. During cross-examination, she was asked about "cancellations" of her psychological assistant registrations, seemingly in an attempt to undermine her testimony. However, as Dr. Gayles explained, the registrations are affiliated with the psychologist who supervises her and when that supervision ended when she had a new employer, the registration was canceled and a new registration was issued that was affiliated with her new employer. Of note, this testimony was consistent with Business and Professions Code section 2913 and California Code of Regulations, title 16, sections 1391.1, and 1391.11, the latter of which requires a registered psychological assistant to notify the Board of Psychology of any changes in supervision or service location. In addition, California Code of Regulations, title 16, section 1391.12, requires annual renewal of registrations. As such, Dr. Gayles's cancellations of her registrations did not detract from her testimony as they were due to her changes in employment.

311. Dr. Gayles discussed the records introduced, the significance of the findings in those records, and how they supported WRC's position. Dr. Gayles's

testimony suggested that all the documents in evidence at this hearing were reviewed by WRC, even ones not reviewed by Dr. du Verglas and Dr. Rodriguez-Cortes. Dr. Gayles also explained how the eligibility team referenced the ARCA Guidelines.

312. Dr. Gayles did not administer any testing to claimant, did not help select what tests were administered to him, and did not interpret any of the tests. She did not recall specific questions asked of claimant or if follow-up questions seeking more details were asked of him.

313. Dr. Gayles began working at WRC in November 2024, so could not answer questions regarding any discussions or meetings referenced in WRC notes before then. She described the meetings in which she was involved, testifying that after reviewing all the documents, the eligibility team "determined that a multidisciplinary assessment needed to be done," which is why Dr. Prater performed her assessment to evaluate claimant's adaptive functioning skills.

314. Dr. Gayles explained that Dr. Prater's assessment was performed, in part, because Dr. Rodriguez-Cortes had claimant complete the ABAS during his assessment whereas Dr. Freeman and Dr. Cronin had claimant's mother complete it, which resulted in very different scores being obtained. Dr. Gayles acknowledged that individuals with disabilities are not the best historians and Dr. Freeman and Dr. Cronin had administered the ABAS to the person who was the better historian.

315. Dr. Gayles observed Dr. Prater's assessment, after which she discussed her observations with the eligibility team which the team considered as part of its determinations. Dr. Gayles's behavioral observations of claimant during Dr. Prater's assessment were consistent with those observed by Dr. Rodriguez-Cortez during his assessment. Dr. Gayles further explained that based upon the eligibility team's review,

which included assessing claimant's cognitive skills and adaptive functioning, he was determined to be ineligible for regional center services because he did not have substantial disabilities in three of seven areas as required.

316. Dr. Gayles acknowledged that some of the findings in the records "could be" consistent with autism, but could also be attributable to other conditions. She explained the importance of various findings and how they factored into WRC's determination. For example, she testified that individuals with autism are typically unable to express their needs, but claimant can, and he was able to communicate using full sentences, so that was an important factor in WRC's assessment.

317. Dr. Gayles explained the relevance of claimant's psychiatric history and the medications he was taking, and how his history of hallucinations was not due to autism or Asperger's but were the result of some other condition. Claimant's history of depression was also relevant because depression can impact an individual's activities of daily living and claimant's depression could be contributing to his condition because conditions and symptoms can overlap and his symptoms may not just be due to autism, but could be due to his other diagnoses.

318. Dr. Gayles reviewed the seven substantial disabilities required for regional center eligibility, and how claimant's records documented his ability to care for himself, earn an income, be employed, and live independently.

319. Dr. Gayles explained that claimant's self-reporting on adaptive functioning assessments further showed he had no substantial disabilities. Dr. Gayles noted that although claimant did have less than average adaptive skills, he was still able to do the "basic functions of daily life skills." This showed that claimant could function independently with very minimal support, which supported WRC's eligibility

determination. Dr. Gayles acknowledged that parents, caregivers, and teachers can also provide information on those assessments, but claimant's self-reporting is permissible.

320. Dr. Gayles agrees with the diagnoses made in Dr. du Verglas's/Dr. Rodriguez-Cortes's and Dr. Dubner's/Dr. Prater's reports. WRC did not use the Level 1 findings to determine eligibility, instead that level showed what claimant's level of needs were, and what supports he required, which WRC used to determine his substantial disability.

321. Dr. Gayles disagrees with the diagnoses made by Dr. Cronin and Dr. Freeman. She explained that an individual with an Autism level 3 diagnosis requires very substantial support, the highest level of support, which claimant does not require. Claimant communicates well and does not have restrictive and repetitive behaviors. Individuals with level 3 autism would have severe deficits in verbal communication, possibly be unable to verbally communicate or speak at all, their social reciprocity would be pretty much nonexistent, they would have extensive restrictions in their behaviors, difficulty redirecting their behaviors, and they would require substantial supports across all levels. A person with level 3 autism would not be able to live independently and would require support at all times.

322. Dr. Gayles was asked about the videotape of Dr. Prater's evaluation that she observed. She could not tell if a chat with someone else occurred, but did agree that Dr. Prater was typing. She also agreed that chatting with someone while administering the ADOS-2 was not Best Practices, but again said she could not tell what Dr. Prater was doing and she may have been typing notes. As found above, Dr. Prater did appear at times to be messaging with someone.

DR. CRONIN'S TESTIMONY

323. Dr. Cronin's testimony is summarized as follows: She described the history of autism diagnoses, the stigma attached thereto, and the evolution of the DSM. Autism is a neurodevelopmental disorder which is found in the DSM because of the behaviors that occur. Claimant meets the criteria for this diagnosis. The three severity levels added to the autism diagnosis were created based on service needs, not severity of the symptoms, but these severity levels have been "very problematic because there are no metrics for assigning" a level. Further, the severity of autism symptoms fluctuates over time, so service needs will also fluctuate.

324. Best Practices require obtaining information from multiple sources and getting a long view of what the individual looks like, not just how the individual looks in the evaluator's office. This is why she and Dr. Freeman obtained collateral information from claimant's mother and other records. Here, other than the medical records, the only other source of the collateral information was claimant's mother as there are "not really any other people in his life." When reviewing those other sources of information, one looks for both consistencies and inconsistencies. This is because diagnoses "do not tell us much, we look at how [the individual] is functioning."

325. Dr. Cronin and Dr. Freeman selected the testing they administered because they were less concerned that claimant had autism, as he had that diagnosis for a long time, and they were much more interested in looking at how that diagnosis was or was not disabling to him. They examined how claimant's autism diagnosis was substantially disabling for him in the areas of social communication, perception abilities, and his independent functioning. Claimant's symptoms have gotten worse over time, resulting in him getting more anxious, more depressed, and having an eating disorder because his autism was not treated.

326. Claimant was administered the Social Language Development Test, Adolescent, which is standard practice to do, because no such test has been validated on adults, so the adolescent measures have to be used. The test is not used to make a diagnosis, but the information obtained is used. Individuals without disabilities will score in the 17-year-old range, the high range, because they will know all the information on the test. Here, because claimant's scores were in the bottom range, this indicated he is functioning at or below the level of a 12-year-old. This indicated that relative to his autism, claimant has substantial disabilities in his communication. Claimant is at the early adolescent level in his ability to communicate and have reciprocal conversations. This is consistent with the very one-sided, lecture and list-like aspect of his communication which is caused by his autism. The plan for claimant would be "how to teach reciprocal communication to an adolescent."

327. On the social responsive scale that claimant completed, his scores showed that he has "deficits in social interactions that significantly interfere with his social interactions." He was able to identify the struggles with reciprocal interactions, something that is typical of individuals with autism. Dr. Cronin acknowledged that it is not often that an individual with autism recognizes their challenges in these areas, but claimant does. However, at the same time, he is also missing insight, for example he discussed being unable to get together with friends because they were working and he does not seem to be aware that people work and plan social activities around their work schedules. He does not understand the reciprocity involved to have a relationship. Also, as someone with deficits in these areas, claimant lacked insight to see that being a receptionist at a yoga studio would not be a good employment option. As further examples of lack of insight, he also thought that by moving to Los Angeles "he could be independent when he had never cultivated any of these skills."

As Dr. Cronin said, claimant's challenges do not go away just because he moved to a new city.

328. Dr. Cronin explained that the BRIEF-A test administered to claimant and his mother simply asks questions about tasks, but not specifics. For example the test asks if the individual can do the task, it does not ask whether the individual can finish the task. It does not ask the individual what happens if there is a change in the routine or structure.

329. The BRIEF-A scores demonstrated that claimant struggles with initiative, sustaining attention to the task, and completing the task. This relates to claimant's substantial disabilities because these struggles are connected to all the ways claimant manages his life activities. For example, he can write a grocery list, but he cannot get himself to the grocery store on a regular basis, be in the grocery store for any length of time, and he is rigid in his food choices. He is also rigid in his gym routines.

330. Claimant's mother's scores on the BRIEF-A were different, as she gave him lower scores. This discrepancy is typical and indicates claimant is still struggling in several areas. Moreover, both of the scores obtained are highly correlated with claimant's autism and the difficulties he has with changes and with being rigid. There are impairments across all areas even though claimant's mother scores were lower than the scores claimant gave himself. These scores are but one source of information that show claimant's initiation skills are poor, indicating he has struggles with self-direction and those scores were consistent with other sources of information obtained.

331. Dr. Cronin discussed claimant's strong cognitive skills. As she explained, an individual's cognitive abilities are not predictive of the individual's social functioning and reciprocal social skills. Social skills and cognitive ability are not

correlated. There is no research performed yet that indicates how to predict how an individual with autism will function now and in the future.

332. The issue with the scores claimant has received on cognitive tests is that it has led to a misconception that because claimant can do certain tasks, he does not have substantial disabilities. However, the issue is he is not learning from his environment to build on his skills. Claimant knows he should do certain tasks, but he is not able to do them. He cannot maintain himself, his car, or keep a job. He cannot initiate and sustain relationships. He is vulnerable to being exploited. He cannot recognize the need to advocate for himself. He is highly dependent on others to care for him.

333. Claimant's abilities have also been overestimated because of his public speaking, but that work is rehearsed as he is in his element because he loves to talk about himself. Dr. Cronin opined that although claimant is very literate, his reading, his writing, and his speech are his restricted, repetitive behaviors. He also had a focused interest on basketball in the past. His restricted interests are reading, writing about himself, and talking about himself. His significant disabilities in other areas have not changed.

334. Claimant has substantial difficulties in learning, self-care, self-direction, independent living, communication and economic self-sufficiency caused by his autism. Claimant needs all the same things as an eight-year-old child. He is not functioning well on his own and is struggling to be independent. He has Autism level 3 because of the support he needs due to the fact he has not gotten any support in the past for his autism.

335. The extent of support claimant requires makes him a level 3. He has not developed a foundation of abilities to help him adapt. He does not learn from his environment. His autism keeps him from learning. As Dr. Cronin explained, individuals learn in social contexts, and claimant's autism has significantly interfered with him being able to do that which has resulted in a long history of substantial disabilities. She also noted that Criterion D for a DSM-5 autism diagnosis is synonymous with how the regulations define substantial disability required under the Lanterman Act.

336. Dr. Cronin addressed claimant's employment as a motivational speaker. Dr. Cronin explained that having an inclusion model at autism trainings has now become commonplace. Some sponsors pay those speakers, some just pay their expenses. Dr. Cronin did not offer any testimony as to how claimant is paid for his public speaking and did not seem to know any of those details.

337. Claimant presents well, can present himself well at his public engagements, which Dr. Cronin said is "reminiscent of someone in the classroom who can function well in class." However, those individuals, like claimant, struggle when they do things beyond their routine or are not in a structured classroom setting. Moreover, claimant's public speaking is "just one aspect of his life, you have to look at all" of his life, an evaluator cannot just take one experience and generalize it to all other aspects of the individual's life. Here, WRC generalized claimant's success as a public speaker to conclude he is successful in other areas.

338. Dr. Cronin acknowledged that the report she and Dr. Freeman wrote did not reference claimant's history of hallucinations nor did she and Dr. Freeman attempt to differentiate claimant's behaviors between autism and his other diagnoses or distinguish whether his behaviors were caused by his autism as opposed to being caused by his other diagnoses.

339. Dr. Cronin referenced some of the articles introduced.

340. A 2014 article, *Brief Report: DSM-5 "Levels of Support:" A Comment on Discrepant Conceptualizations of Severity in ASD*, referenced the DSM-5 proposed revisions of adding severity markers to the ASD diagnosis but noted that quantitative methods for differentiating between the three levels remained undetermined.

341. A 2023 article, *Autism severity and its relationship to disability*, noted that individuals with autism are often diagnosed with another medical, developmental, and psychological co-occurring conditions which can impact their adaptive functioning, and that the changing nature of autism symptoms are influenced by these co-occurring conditions.

342. A 2016 publication, *Severity of Autism Spectrum Disorder: Current Conceptualization, and Transition to DSM-5*, supports the concept that a picture of the whole person is needed. There must be a diagnostic interview, a comprehensive evaluation performed using best practices, not just tests performed. Additionally, comorbidities pose challenges for evaluators trying to determine levels of severity.

343. Dr. Cronin was critical of the evaluations WRC relied upon. She noted that both evaluations were performed by "trainees," as she called them, and described how in her experience other regional centers "pushed back" when evaluations were performed by trainees. Of note, she did not testify that WRC was one such regional center.

344. Dr. Cronin was complimentary that Dr. du Verglas's report did a "great job" documenting claimant's history. However, she noted that although testing to diagnose autism was administered, substantial disabilities were not evaluated which "speaks to the trainee not knowing" to do so. Additionally, claimant was given a self-

report checklist, there were no collateral sources questioned, and no realization that claimant may not realize how well or poorly he is functioning given his autism. However, be that as it may, claimant did document struggles in the social skills area, which was consistent with what claimant's mother reported.

345. Dr. Cronin and Dr. Freeman authored their supplemental report because they had concerns with Dr. du Verglas's/Dr. Rodriguez-Cortes's assessment because even though it noted that assessing claimant's adaptive skills was a primary concern, no adaptive skills testing was performed and multiple sources of information were not obtained contrary to Best Practices recommendations. The University of Washington records "got very little attention" even though that was the facility that diagnosed claimant with autism. Dr. Cronin does not know why the Children's Hospital psychiatry evaluation was given great weight, but other records were ignored. Most concerning, there was no evaluation in the Dr. du Verglas/Dr. Rodriguez-Cortes report of substantial disabilities.

346. Dr. Cronin acknowledged she has no sense of the experience level of Dr. Rodriguez-Cortes, but noted experience is needed to perform autism evaluations.

347. Dr. Cronin explained that the ADOS-2 is a standardized diagnostic measure that can be "included in a best practices diagnosis or evaluation" for an individual. It is standardized so all evaluators can achieve accurate results. If it is not administered per the standards, there can be "a variety of errors." There are five modules to the ADOS-2 and if the evaluator gives the wrong module it will not reflect accurate results of what an individual looks like, and someone may be diagnosed with autism who does not have it and vice versa. Dr. Cronin has trained between 600 and 1,000 psychologists on how to administer the ADOS, doing so at ADOS training

classes, as well as training individuals she supervises. She has also given ADOS trainings to regional centers.

348. Dr. Cronin observed the videotape of Dr. Prater's assessment and opined that Dr. Prater did not administer an ADOS, even though her report indicated she did.

349. Dr. Cronin opined that for Dr. Prater's report to indicate she administered an ADOS when she did not, constitutes a false report. During the assessment, Dr. Prater "was distracted, not present, and frequently on her computer." She "did not make herself available" to either claimant or his mother. She was not engaging, she was not interacting with claimant. When looking at substantial disabilities, the evaluator must be present which is something learned from experience, and Dr. Prater was "a trainee."

350. Dr. Cronin opined further that during Dr. Prater's assessment, claimant's "deficits in social, learning, communication and emotional development were all evident." He was lacking in those areas. He would go on tangents and use repetitive speech patterns. Dr. Prater "did not recognize what was happening because she was not paying attention." Her conduct during that assessment was "egregious" and "borderline malpractice," and she could be reported to the Board of Psychology.

351. Dr. Cronin acknowledged that there was no place in their report that they differentiated claimant's behaviors between his autism, anxiety, and OCD. They did not reference hallucinations in the report because they were not trying to attribute any of his behaviors to hallucinations. They also did not distinguish autism from hallucinations, OCD, or anxiety. Nor did they distinguish them from his depression. She also agreed that claimant's medications are to treat his psychiatric symptoms that are related to those diagnoses.

352. Dr. Cronin and Dr. Freeman did not diagnose claimant with anxiety because he is not presenting with that condition now. He has a symptom of anxiety but that is directly related to the social deficits and difficulties that are caused by his autism. Once he gets supports for his autism, it is their "hope" his anxiety will decrease.

353. They also did not diagnose claimant with OCD because when they looked at what was causing his distress, his repetitive behaviors were comforting to him which is "not something captured by an OCD diagnosis." As she explained, an individual with OCD exhibits distress at the need to perform certain behaviors, a distress which claimant does not have.

DR. FREEMAN'S TESTIMONY

354. Dr. Freeman's testimony is summarized as follows: She is currently retired. She described her extensive history working in the autism field as reflected on her CV. She treated approximately 10,00 to 15,000 individuals with autism, which was her specialty. She was involved with writing the original definition of autism before it was even in the DSM.

355. Dr. Freeman served on the DDS advisory committee for the creation of the Best Practices document which was to serve as a basis for the assessments regional centers performed. It was "a dynamic document that was developed over time as things changed" and intended to "keep pace with those changes and train regional centers about what to do." She explained that when Best Practices are not followed, it leads to "cases like we have today."

356. A developmental history for autism is important to obtain. Here, claimant's mother was trying to get help for claimant from as early as when he was two years old, but was unsuccessful.

357. The developmental history documented in Dr. du Verglas/Dr. Rodriguez-Cortes's report was very thorough, but different conclusions were reached from those reached by Dr. Freeman and Dr. Cronin. Dr. Freeman acknowledged that Dr. du Verglas is "a very experienced autism examiner," but noted she was not the one who administered the tests to claimant, so that was "a concern" for Dr. Freeman. Moreover, that assessment was "not a real assessment of substantial disability." Although WRC referred claimant to assess his "adaptive levels of functioning," that assessment was not performed. As Dr. Freeman noted, adaptive behavior skills will give a better idea of an individual's prognosis.

358. Dr. Freeman was also critical of Dr. du Verglas's report because it did not obtain collateral sources of information. Only claimant served as the informant for the ABAS-3, it was unclear why his mother was not also given the ABAS-3. An issue with only questioning claimant is that he does not see his behaviors as others see them. It is important during any assessment to talk to others and not just the individual being assessed; collateral sources are important.

359. Dr. Freeman reviewed the videotape of Dr. Prater's assessment noting that "no matter what question was asked," claimant answered how the autism affected him. Claimant talked constantly, had pressured speech, and every question asked of him came back to him talking about himself and his autism. His "repetitive and perseverating way of answering questions was his autism." His reading books and writing poetry was his autism.

360. Dr. Freeman opined that parts of Dr. Prater's report are inconsistent. For example, at one point she wrote that claimant did not initiate discussions and at another she wrote that he had fluid discussions, but she did not address that discrepancy in the report.

361. Further, Dr. Freeman opined that Dr. Prater did not perform an ADOS but did use some ADOS questions during her assessment. Dr. Freeman opined: "if that tape is the ADOS, it clearly was not standardized," and the videotape does not show any of the five items from the ADOS being administered. There is a part on the videotape where claimant is telling a story from a book shown to him, which is a test from the ADOS, but that test was only partially administered to claimant and several questions on the ADOS that are supposed to be asked in a standardized way were not asked.

362. Dr. Freeman explained there is "lots of concern regarding how the ADOS is misused." She referenced a 2023 article claimant introduced, *Commentary: Best practices and processes for assessment of autism spectrum disorder - the intended role of standardized diagnostic instruments*, in support of her opinion. The article discussed how improper administration of ADOS can result in false positives and false negatives, how the ADOS was not intended to be used as the only way to diagnose autism, and how clinicians' experience, training, and biases can lead to a wide range in how autism cases are defined.

363. Dr. Freeman explained how the two-day ADOS training course is not sufficient to conclude that one is fully trained. In her clinic, it took six months of using the ADOS "to obtain reliability." The two-day ADOS course is intended for individuals who have a good baseline knowledge of autism and young clinicians, such as Dr. Prater and Dr. Rodriguez-Cortes, have simply not had enough time to develop those skills. However, Dr. Freeman acknowledged she does not know what training either of those individuals has had.

364. In reviewing claimant's records, Dr. Freeman was not concerned with what other clinicians concluded, she was concerned with the behaviors documented

and here those behaviors showed autism. In claimant's case, it was "pretty straightforward he had substantial disabilities from very early on" due to his autism.

365. Intellectual functioning is not a criteria for autism. Dr. Freeman is not sure why it is relevant. As she opined, "it is just one aspect" and the clinicians performing the WRC evaluations "missed out on all else." Dr. Freeman opined that it seemed the focus was on claimant's intelligence, which is a strength for him, "but that is not all there is, there is more to claimant." Dr. Freeman explained that in normal development, there is a direct correlation between intellectual functioning and adaptive functioning. With autism, there is a discrepancy seen between those two functions. Here, the discrepancy between claimant's IQ scores and his adaptive behavior skills is due to his autism.

366. Claimant has good verbal skills and had good academic progress when he was in school, but the reports do not reference his day-to-day functioning. It appears that because claimant has good language skills, it was determined he had no issues, but that is not true. He cannot initiate discussions and he did poorly on the social language testing administered to him.

367. WRC seemed to focus on claimant's cognitive skills, "but autism is so much more than cognitive skills." In the past, 70 percent of individuals with autism also had intellectual disabilities, but now it is 30 percent "as more and more people with autism are not cognitively challenged." Individuals can have normal intelligence but are not using it because of their autism. Severity levels in the DSM-5 are not just based on cognitive skills, the individual also has to be able to communicate, have adaptive skills, and have social-emotional functioning.

368. Currently there is not a measure of how to determine severity levels. Moreover, autism is a spectrum disorder and an individual's severity levels change over time. In fact, Dr. Freeman and Dr. Cronin authored a textbook chapter on adaptive behavior and how it changes over time.

369. Dr. Freeman opined that it is "pretty straightforward" that claimant has autism when one knows how to make the diagnosis and the articles claimant's attorney presented address the issues regarding diagnosing autism. Dr. Freeman has "been doing this for 50 years and it saddens me to hear [claimant's mother's] testimony. We are still in the same place 25 or 50 years later." Dr. Freeman explained that although "we have come a long way, we are still stuck that we need a certain test score" to diagnose autism.

370. Dr. Freeman believes WRC's denial is due to claimant's test scores. However, the objective measuring tools used for evaluating autism are just one measure used to diagnose it. Those measures should not be the only tools used as autism is a clinical diagnosis. WRC also incorrectly determined that because claimant did not appear as the same person his mother described in her test scores, this meant claimant's mother's scores were not valid. However, the difference in the test scores showed that claimant has different behaviors under different circumstances.

371. Dr. Freeman added it is important to analyze claimant's behaviors in the past and in multiple environments, because individuals with autism often function differently in different environments and those inconsistencies are a "hallmark of autism," so clinicians have to be very careful not to conclude a person does not have autism because they work well in one environment. While claimant may have done well in school, when he has to apply that learning to a different environment, or if

something new is introduced to his environment, he cannot perform the task or he knows what he is supposed to do, but he is unable to do it.

372. Dr. Freeman discussed claimant's abilities to perform a skill versus whether he actually performs it. Whether claimant "can" perform a skill is "more of a capacity assessment." The issue is why is claimant not performing that skill, and "in all likelihood it is due to his autism." Claimant can do things, but he does not because of his autism which is why she assessed claimant Autism level 3. He needs the same service as others who may be impaired cognitively. He also does not do tasks because he is not motivated and he needs services to motivate him.

373. Claimant had varying receptive and expressive language scores but his ability to initiate and carry on conversations or read social cues is extremely limited which can be seen on the videotape and with the findings on the social language testing administered. Claimant also does not learn from his environment as would be expected from someone with his cognitive abilities. An example is his belief that just moving to Los Angeles is all that was required to change his life without thinking of what he had to do when he got there.

374. Claimant moved to Los Angeles to get more friends and a job, but he did not understand that he did not have the skills to do either one. He is unable to learn in his environment. Claimant has decided he should be married with children, have a job, and has conceptions of how he should be, and he is always trying to be someone he cannot be, so he needs help. Claimant's life is what it is because he was never properly diagnosed and given appropriate treatment. This is why he needs a lot of services right now which makes him a level 3.

375. As far as economic self-sufficiency, Dr. Freeman testified that claimant receives SSDI and was deemed eligible because he is unable to work due to his disability. Claimant is very frugal. His SSDI pays his rent and he uses the savings he accumulated when he worked as an aide at a Nevada autism school to pay for his other expenses but he has no plan what he will do when his savings run out. Further, claimant left his Nevada school employment because he was too stressed out to work there.

376. Dr. Freeman acknowledged she does not know claimant's qualifying criteria to receive SSDI. It is her understanding that claimant's autism keeps him from being able to work. She assumes claimant receives SSDI because he cannot be gainfully employed. She does not know if SSDI criteria is more or less rigorous than regional center eligibility criteria, and does not know the SSDI criteria for autism, although she does know the SSI criteria for autism which examines how the autism "affects the [individual's] ability to work in a work setting." She is aware that individuals must provide more information for an SSI evaluation than they have to provide for a regional center evaluation. One of the recommendations Dr. Freeman and Dr. Cronin made was for claimant to receive SSI.

377. Currently, claimant does not have a capacity for independent living. Dr. Prater's report acknowledged the difficulties claimant has with self-direction and the capacity for independent living. Claimant's lack of self-direction "is a hallmark of autism." Dr. Freeman opined that Dr. Prater also agreed that claimant could not do self-care tasks which is a significant functional limitation and that Dr. Prater's report "clearly identifies" that claimant meets at least three areas of substantial disability.

378. Regarding claimant's other diagnoses, Dr. Freeman noted that 70 percent of individuals with autism have one or more coexisting psychiatric disorders and 40

percent of individuals with autism have two or more psychiatric conditions, statistics which are referenced in the DSM-5. Dr. Freeman does not know what percentage of individuals with a psychiatric diagnosis also have autism.

379. Dr. Freeman explained that the difference between repetitive behaviors for those with OCD and those with autism is that individuals with OCD do not like that they have to perform repetitive behaviors, whereas individuals with autism do these routines as part of their life. For claimant, these help him gain more structure in his world. Helping claimant learn that routines can be interrupted will be "a long-term and difficult process" as his routines are related to his autism.

380. Dr. Freeman acknowledged that the DSM-5 does not define substantial disability; that term is defined in the Lanterman Act and regulations. The DSM-5 discusses qualitative impairments and substantial disabilities are not required for a DSM-5 diagnosis of autism.

381. Dr. Freeman opined that WRC's denial was wrong and she agrees with Dr. Cronin's opinions. The assessments performed show that claimant has autism and substantial disabilities due to his autism. While some individuals with autism and substantial disabilities can be successful, claimant is not one of them. With proper services, he can get better, but it will be a long process because he is 35 years old and has never received proper treatment.

CLAIMANT'S MOTHER'S TESTIMONY

382. Claimants mother's testimony is summarized as follows: She described claimant's birth and developmental history. Claimant was born via an emergency C-section, placed on oxygen, and given "sugar water" to increase his muscle tone because he was a "floppy baby." He was released from the hospital after five days. He

was a “big baby.” He was pretty quiet, slept a lot, and did not cry. His milestones were delayed as he was not sitting or walking during the time frames expected due to his poor muscle tone. An illness at 18 months old led to claimant being hospitalized in the intensive care unit for three days, after which he reverted to crawling as he was too weak to walk. The illness required him to be intubated and placed on a breathing tube, and his heart rate decreased.

383. As a toddler, when he was enrolled in preschool, claimant did not join others, remaining in his cubby the entire time, despite his teachers’ efforts to get him to engage. When he began at the Montessori school, he did better because it was a more structured and less chaotic environment.

384. At home, he would not play outside with the neighborhood children. When he began kindergarten, it was difficult to wake him up in the morning so he was enrolled in the afternoon session. Despite a neighborhood friend who wanted to play with him when he came home, claimant was too tired and would nap after school. In his life, he had one neighborhood friend and one best friend when he was older.

385. Claimant carried a pillow around with him for comfort that he named. He still has it and still uses it to self-soothe. Claimant would hold his pillow, suck his thumb, and hide behind his mother’s leg.

386. At times when claimant became anxious, he would hold his breath, turn blue and pass out. Claimant’s physician advised that claimant was much older than a “typical child” who holds his breath during stress. There were times over the years where claimant became overstimulated and coped by withdrawing, going off by himself, and could “sit for hours” quietly in his room or watching TV. As he got older, he could tolerate more activity, but he still did not engage much with others.

387. Claimant did not need help with dressing, he just needed help staying on track to get ready on time. Claimant's mother would lay out his clothes for him but he could dress himself. She purchased shoes with Velcro straps because tying his laces was "complicated" and he did not like them. Claimant was very particular with what he would wear. He never wore jeans. He cut the tags off his shirts. He was very sensitive to clothing.

388. Claimant was also extremely sensitive to sounds, and certain noises would greatly increase his stress. He would cover his ears and have "significant meltdowns" in response to various noises. Even today, if a car pulls up next to him with its radio playing loudly, or when his neighbor has gatherings, which happens frequently, the noise of those events is very distressing.

389. Claimant is also extremely particular about his food choices. He has had a pretty rigid diet since he was a young child. He prefers to eat with a tiny spoon and he does not like his food to touch.

390. Claimant's mother described a Europe trip where claimant bolted approximately 10 times. It was the family's first trip to Europe and claimant had severe difficulty at the first country they visited. He developed an immediate fear of bridges, refusing to go over them so they had to rework many of their walks and/or run across the bridge quickly. Claimant would only eat at McDonald's during the trip, he would not try any different food.

391. Claimant enjoys reading. As a child he loved reading books about successful athletes and would emulate things they did. He also loved cars, especially Corvettes, and kept a notebook of the number and color of vehicles he observed.

392. In grade school, the school year would start off well, but claimant would eventually refuse to attend school because of his anxiety and he missed lots of school over the years. However, he was always able to complete his schoolwork and maintain his grades, he just did not want to attend classes.

393. In first grade, he had a best friend who moved away without warning which caused claimant great sadness and led him not wanting to return to school.

394. Claimant also struggled because he had a speech impediment and his third grade teacher was "very gruff" and would tell him to speak up and that she could not understand him which only caused him to retreat more.

395. "At this point," claimant "was getting professional help." Claimant's mother spoke with his pediatrician who referred her to a behavior specialist

396. In fourth grade when claimant's braces were removed, he did not want to return to school because he thought the students would ask him why he looked different.

397. In fifth grade, claimant told his mother he was engaging in very repetitive behaviors that his mother was not aware were happening. He told her the behaviors were impacting his ability to pay attention in school and he found them exhausting. He described having to count everything and tapping on his desk, the latter of which his teacher also observed him doing. Claimant also reported doing "lots of handwashing" that his mother also did not know about.

398. By fifth grade, claimant's panic attacks were causing him to cry, and escalate to the point of his body shaking and he refused to go to school, although he continued doing his schoolwork. At this point, claimant was seeing both a psychologist

and a psychiatrist and was diagnosed with severe anxiety and OCD. The clinicians described claimant as "a terrified little boy."

399. Claimant did not have an IEP in elementary school. The school did not think he needed one as he was not diagnosed with anything more than anxiety and OCD and his schoolwork was on track. Claimant's mother was "not even aware what an IEP was" back then. She had meetings with the principal, claimant's teachers, and perhaps the school nurse, but no one ever suggested or recommended an IEP for claimant.

400. Claimant's psychiatrist eventually recommended inpatient care because claimant's behaviors were escalating. Claimant started seeing things that were not there, and his visions were usually related to blood. He saw blood coming out of his feet, and he saw someone sitting in the tree outside his bedroom window with blood dripping from their body. He drew pictures of what he saw to convey his visions to his mother. His pictures were very concerning. He also developed a phobia to bugs and refused to go outside. He would duck his head and swatted his arms crying. He saw giant bugs chasing him. He also started bolting and running away to get away from things.

401. Claimant's psychiatrist's recommendation for inpatient hospitalization was "not taken lightly" by claimant's parents. It was a difficult decision to make but they were desperate. They discussed the side effects with the psychiatrist but decided to do it because claimant was visualizing blood, seeing people in his tree, and seeing oversized bugs. Claimant's psychiatrist felt she had done all that she could and she was at a loss to provide further help for claimant so she recommended in-patient hospitalization. Claimant was initially on a waiting list, but a few weeks later a bed opened up, and the family accepted it.

402. Claimant did not have much success at the hospital and did not receive a diagnosis more than severe anxiety. It was a very frustrating experience. Claimant's mother believes that claimant's anxiety became much worse. There was a period during the hospitalization when the family was not allowed to visit claimant as the hospital was trying a separation technique to get him to decrease his stress. The director of the psychiatry unit scolded claimant a few times for not making eye contact with her when she spoke with him which was something that really "stuck with" claimant's mother.

403. The discharge from the hospital and transition back to school did not go as planned. The family was told that hospital staff would attend school with claimant to help the transition, but instead they merely greeted the family at the front of the school, did not go inside, and "we were on our own again." Claimant's transition back to school was "a disaster." From the beginning, the school refused to create an IEP which resulted in the family filing an appeal with the school board to finally get one.

404. At discharge, claimant's pediatrician read the reports and he was the one who thought that claimant had Asperger's syndrome and he referred claimant to the University of Washington Autism Center where claimant received testing which showed he was on the spectrum. Because of the pediatrician, they were also referred to a new psychiatrist and a new psychologist. As result, they were able to get an IEP under the autism category. However, claimant did not go to classes, he stayed in his counselor's office where he slept most of the day on the couch. He always had the hood of his sweatshirt over his head to "block out sensory things."

405. Later, claimant was placed in a specialized school which was very accommodating, had small classes, teachers who were trained in autism, and the school followed the University of Washington's recommendations. The school

appeared to understand claimant "in ways no one else had before." Because he did so well, that school recommended transitioning claimant back to his "regular school," and that was "very destructive and harmful" to claimant. In claimant's junior year his parents pulled him out of school and enrolled him in a program for students who had dropped out of school. Claimant was not happy about it, he felt it was a punishment and a stigma.

406. Claimant's meltdowns also got worse over time. As he got older and there were "more expectations from the world" placed on him, he found this more distressing. If he was out in public and ran into someone, he found it very distressing to have to speak to that person. After claimant has a meltdown, he will withdraw and go to sleep. Other stressors for him include unpleasant events he sees on TV. Claimant also reported he can smell people on TV and can smell people in public.

407. Claimant recently had a meltdown at an airport with his mother when a plane from an air show flew overhead, which was extremely noisy. Claimant started screaming and ran inside the airport terminal. He punched a hole in the wall because he was so stressed out and airport security was called. Claimant's mother had to explain claimant's condition to them. These types of incidents "have happened with [claimant] fairly frequently."

408. Claimant was really excited about the family's move to Nevada. He "wanted a fresh start." Claimant's mother was "on the fence" about the move, but claimant was "very excited." He wanted "to leave the past behind him" which was "how he verbalized it."

409. After the move to Nevada, claimant did pretty well. He enrolled in high school and had an IEP that the school was "very conscientious" about following. The

school did not have much experience with autism but wanted to "do their best to meet claimant's needs and make it a good experience for him." His IEP category was autism.

410. At the first meeting with school officials, claimant's teacher, counselor, and the football coach attended. Claimant was interested in playing for the football team and the school structured classes that allowed him to do so. He had a weight training class in the morning and one or two other classes. He attended school "a little bit" but still did most of his work at home but he would go to the weight training class because he was motivated to do that so he could play football. (Of note, claimant's mother testified about football, but all the records referenced basketball; this discrepancy was not explained at hearing.)

411. Claimant adjusted very well to the Nevada move. He got his driver's license and his father was not working at the time so he was able to spend more time with claimant. However, claimant was still struggling and found it difficult to go to school. He graduated with "help from Nevada and the school counselor" and was able to complete his GED.

412. She does not recall anyone ever mentioning vocational training for claimant. After graduating high school, he was not employed and she does not know if he would be able to "follow-up with being employed." He expressed a desire to attend college, but even though excited to do so, because of his lack of social skills and follow-up, he would "withdraw when he got there." Of note, it was unclear from this testimony whether claimant ever enrolled in college.

413. Claimant's mother has "little hope" claimant could be employed. She applied for SSI for claimant "pretty soon" after they moved to Nevada. A psychiatrist or

psychologist approved her application after claimant was evaluated and she believes he is still receiving those benefits.

414. Claimant did not make any friends in Nevada. He made the football team and was successful because of the coach who did an "extraordinary job making [claimant] feel accepted and included in an upbeat way." There were team dinners once a week and she only later learned that claimant never talked to any of his teammates during practice, and never said "Hi" to any of them at the dinners, in the weight room, or at practice. Claimant had "no idea how to talk to them or anything." Claimant's mother thought he had friends but he did not.

415. Claimant began participating in the Autism Society in Nevada. He met some people who were part of that society and they encouraged him to attend functions. Claimant was "very proactive trying to find help and assistance for himself." In Nevada, claimant "would research who he could contact, who he could reach out to as far as trying to find a group that he belonged to."

416. Claimant would also work out a lot. It was his "obsession." He would say, "I do not have a good day if I don't work out." He began going to a gym near their neighborhood and started buying lots of weights. He had "quite a collection of weights" and would work out in his room. He was also jogging and would wear a weight vest when jogging.

417. After working out for a few hours, claimant would get cleaned up and the rest of the day he would shoot basketballs outside or spend time with his father, but not do much more. He had "no confidence in being social." He did "lots" of reading, he was "definitely educating himself." He always read history books and biographies. He also wrote poetry. He did not do anything that she would define as "negative

behavior." He would wait for claimant's mother to get home from work and they would spend time together. She would help him with cooking, he had an interest in cooking, and they would cook together "before he started having problems." Claimant "developed an eating disorder" and "things got bad for him for quite a while." He also developed arthritis in his toes and had surgery.

418. Claimant was caring for his hygiene until he developed his eating disorder and "sunk into pretty significant depression." He would wear the same clothes every day, he was not showering, and as he got weaker, he did not work out.

419. Claimant's father also had a lot of problems. He did not do well at work. He was an alcoholic, and claimant's mother was "always dealing with that," so once claimant was "in depression I did is much as I could talking to him and getting in touch with what his feelings were," but she was "working part-time and felt pretty helpless."

420. Claimant's father was getting worse with his alcoholism. They were taking claimant to a psychiatrist and his father tried taking him to a hospital for his eating disorder "and that became an enormous battle." Claimant was accepted to an out-of-state hospital that specializes in eating disorders and they flew there to admit him. However, when they arrived, the hospital changed its mind and decided claimant could not be admitted.

421. They contacted Nevada social services in their county and "some people" came to the house to evaluate claimant and were "pretty alarmed" by his condition. Claimant always had sweats on with the hood up, and was sitting on the couch all day in the exact same spot with a blanket over him, which he sometimes put over his head. He would just sit there like that all day.

422. Claimant's mother was concerned with claimant's mental state. However, she did not feel that the symptoms of his mental state were a high priority, she was more concerned about him not eating, not changing his clothes, and not showering. However, when they lived in Nevada, they never really got any help for this.

423. After she and claimant's father divorced, claimant moved in with her to her new home in Nevada. Later, she told claimant he needed to try and live on his own so he got his own place a mile or two away. He would stay there during the day but come over when she got home from work, so they were "kind of still living together."

424. A few years after she and claimant's father divorced, claimant decided to move to Los Angeles. He found a place by himself which he "did all online." He looked at places, contacted landlords, and arranged for all that without any assistance from his mother. He moved into his place after only seeing it online. It turned out to be a good fit, it is an Accessory Dwelling Unit (ADU) on private property. The landlord is "very motherly and very protective" of claimant, and it was a good transition for him.

425. Claimant's mother's most recent visit to Los Angeles was "horrible." Claimant was doing a little bit better now because his California psychiatrist has changed some of his medications and he was able to put some of his belongings away. However, his place looks the same as it did two years ago when he moved into it. He still has stacks of books on the floor that he has not put on the bookshelves. She helped claimant order bookshelves and other items he needed when he first moved into the unit, but he has "very little" in the way of organizational skills.

426. Claimant usually has dirty clothes in a pile in his bedroom and when he washes them he puts them on a chair or the bed. He does fold them, and rarely puts

the clothes away. His dishes are clean and he is very particular and specific with how he prepares his food.

427. Claimant's mother purchased his car insurance because he "really struggled with that." For his vehicle maintenance, he will make an appointment online, he will not call to schedule an appointment, and he takes his car to a shop near where she lives, approximately two hours away, so that they can go together.

428. Claimant's public speaking engagements are obtained "through his own motivation to contact people. He has always felt he does not want others to suffer like he has, to not be understood, to not get help." He will contact the organization. He likes to write, introduce himself to the organization, tell them of his background, and ask them to meet.

429. Both claimant and his mother schedule claimant's appointments with the current psychiatrist. Claimant "does as much as he can" but she will help coordinate certain aspects of his psychiatric care. She went with claimant to his first psychiatric appointment so that he would "feel better and open up and let the psychiatrist know all that was going on." Claimant handles his prescriptions, but claimant's mother has "to intervene a lot" because if there is a mistake, claimant will not call the pharmacy and tell them, so claimant's mother has "a specific person" she calls at the pharmacy.

430. In summation, claimant's mother stated that claimant is "so much more than anything I can ever describe." He has "struggled his entire life to be somewhat normal and it's been the theme of his life that he rarely gets the help he needs. It is miraculous he is doing as well as he is and it is all through his own grit and unwillingness to give up."

431. Claimant's mother made a credible witness and was a good historian. It is clear she wants what is best for her son and is seeking ways to help him.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. In a proceeding to determine eligibility, the burden of proof is on the claimant to establish he or she meets the proper criteria by a preponderance of evidence. (*Tri-Counties Association for Developmentally Disabled, Inc. v. Ventura County Public Guardian* (2021) 63 Cal. App. 5th 1129, 1138–39; *McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052, fn. 5; Evid. Code, § 115.)

Statutory and Regulatory Authority

2. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

3. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance . . .

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

4. Welfare and Institutions Code section 4512, subdivision (a), states in part:

As used in this division:

(a)(1) "Developmental disability" means 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.

(2)(A) A child who is under five years of age shall be provisionally eligible for regional center services if the child has a disability that is not solely physical in nature and has significant functional limitations in at least two of the following areas of major life activity, as determined by a regional center and as appropriate to the age of the child:

(i) Self-care.

(ii) Receptive and expressive language.

(iii) Learning.

(iv) Mobility.

(v) Self-direction.

(B) To be provisionally eligible, a child is not required to have one of the developmental disabilities listed in paragraph (1).

5. California Code of Regulations, title 17, section 54000, provides:

(a) "Developmental Disability" means a disability that is attributable to mental retardation,[2] cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related

[2] The regulations still use the term "mental retardation," which was replaced with the term "intellectual disability," which has since been replaced with the term "intellectual developmental disability."

to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

6. California Code of Regulations, title 17, section 54001, provides:

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

School Categories versus Eligibility

7. Claimant receiving special education services under the autism disability category is not controlling for regional center eligibility. Unlike regional centers, school districts are not governed by California Code of Regulations, Title 17, which has much more stringent requirements for regional center eligibility.

Evaluating Expert Opinions

11. In determining the weight of each expert's testimony, the expert's qualifications, credibility, and bases for the opinions must be considered. In resolving any conflict in the testimony of expert witnesses, the opinion of one expert must be weighed against that of another. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.)

12. The failure to consider all of the facts may make the expert's opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614), and the expert may be examined about whether the expert sufficiently took into account matters arguably inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

13. "Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon [by] other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.]" (*Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135-36.)

14. Relying on certain portions of an expert's opinion is entirely appropriate. A trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits

of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at pp. 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal. App. 2d 762, 767.) The fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

Evaluation

15. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet in order to qualify for regional center services. The parties agreed claimant had autism; the issue was whether his autism constituted a substantial disability for him. Based upon the record, claimant did not establish by a preponderance of evidence that he has a substantial disability due to his autism.

Claimant failed to show he has "significant functional limitations" in three or more of the required seven areas. He cares for his personal hygiene needs and is able to grocery shop and prepare meals, although he needs some support. His vocabulary and the appropriate follow-up questions he posed to Dr. Prater demonstrated his receptive and expressive language strengths. He also was able to engage with Dr. Rodriguez-Cortes during that evaluation. Claimant's self-described love of reading so as to learn showed a very intelligent person who is capable of learning. His scores on cognitive tests and his grades in school also demonstrated his learning abilities and strengths. He does not have mobility issues. He possesses self-direction skills as he was able to seek out public speaking opportunities, move on his own to Los Angeles, and seek out both housing and employment opportunities. He obtained Medi-Cal benefits and sought psychiatric and regional center services on his own. He even attended many of his WRC eligibility evaluation sessions alone. Claimant knows what he wants to do and has dreams for himself, he just needs some help achieving them.

He lives on his own and financially supports himself with most of his expenses, so he has the capacity for independent living and economic self-sufficiency, albeit he needs some support. As defined by the DSM-5, the support claimant needs is level 1, as WRC correctly determined.

In his closing brief, claimant requested a "specific finding that his receipt of SSDI alone is sufficient to prove by a preponderance of the evidence that he has a significant functional limitation in the major life activity of economic self-sufficiency." Other than the fact that the "Final Statement of Reasons" stated that Welfare and Institutions Code section 4512 was amended, in part, to conform to how the federal government defines substantial developmental disability, no authority was cited for claimant's proposition that qualifying for SSDI benefits results in an automatic finding that claimant has a significant functional limitation in the area of economic self-sufficiency as that term is used in the Lanterman Act and regulations. Claimant's SSDI and SSI qualifying disability was not listed in the documents introduced so it was not established that his benefits were awarded due to autism. Even if they were, there was no showing that the SSDI or SSI qualifying factors were the same as the eligibility factors used by regional centers. Claimant's argument is rejected.

The evidence did not demonstrate that claimant requires "very substantial support." Even prior treaters who diagnosed claimant with autism, diagnosed him as "High Functioning" or with "Asperger's." They, too, noted claimant's high functioning abilities, which further supported WRC's determination that claimant's autism was severity level 1. While claimant reported various issues, the evidence did not show he had "extreme difficulty coping with change," or that he had other restricted or repetitive behaviors that markedly interfered with his "functioning in all spheres," or that he had "great distress or difficulty changing focus or action," as the DSM requires

for severity level 3. Claimant looked forward to moving to Reno and later to Los Angeles, travels for his work, and is willing to make changes to improve his life, demonstrating he is not restricted and not unwilling to change his focus or his actions. Although he requires assistance from his mother to complete some tasks, the evidence on the whole, did not show he needs "very substantial support."

While claimant correctly pointed out that the DSM-5 cautions that the "severity categories should not be used to determine eligibility for and provision of services," there was no authority provided that this dicta in the DSM-5 overrode the Lanterman Act or the regulations. The Lanterman act and the regulations are controlling and require both a diagnosis of autism and that the autism causes a substantial disability, which is defined as a condition which (1) results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, and where (2) there are the existence of significant functional limitations, as determined by the regional center, in three or more of seven enumerated areas of major life activity.

To determine whether an individual has "significant functional limitations" due to autism, WRC considered the severity levels of the autism diagnosis. Here, the evidence simply did not show that claimant requires "very substantial support" as Dr. Freeman and Dr. Cronin opined. The evidence did not show, as required by severity level 3, that claimant has "severe deficits in verbal and nonverbal social communication skills" which cause his issues. He spoke eloquently and fluidly as seen on the videotape, using a very large vocabulary. Contrary to claimant's experts' opinions, claimant demonstrated a key insight into himself, his abilities, his limitations, and his social interactions, which he was able to clearly express. This is something which would

not be expected in someone with Level 3 autism. Even Dr. Cronin acknowledged that claimant's insight was not typical of one with autism.

Claimant was able to clearly describe his condition, his desires, and the support he seeks, none of which showed he needed "very substantial support." Dr. Freeman's and Dr. Cronin's testimony of what they observed on the videotape was not consistent with what that videotape showed. Dr. Prater was not disinterested, not inattentive, and allowed claimant to answer all questions posed to him. She clearly developed a rapport with claimant during her assessment and was fully engaged with claimant, asking detailed questions about his activities of daily living, his lifestyle in general, and how he takes care of himself, as well as other areas of inquiry. She asked follow-up questions, answered claimant's clarifying questions, and allowed claimant and his mother to answer and respond. Although during the assessment Dr. Prater moved between different computer screens, she remained fully-engaged with claimant. It did not appear her changing screens caused her to disengage from the conversation or show she was otherwise distracted from her assessment.

Dr. Freeman's and Dr. Cronin's opinions that claimant only spoke about himself during Dr. Prater's assessment proving he had severity Level 3 autism, missed the mark. The purpose of the assessment was to interview claimant, so asking him questions and having him talk about himself was the very reason for the assessment. Nothing about how he answered questions showed a restricted or perseverating demeanor and he was able to switch topics as Dr. Prater asked her next question. Dr. Freeman's and Dr. Cronin's criticism that Dr. Prater administered an incomplete ADOS was not persuasive or credible based on the video of Dr. Prater's interview with claimant and his mother. They also failed to specifically point out what was lacking and the details recorded in Dr. Dubner/Dr. Prater's report were consistent with the answers

and observations obtained during the assessment and seen on the videotape. Further, claimant's mother's scores on the ABAS-III were inconsistent with how claimant presented and was observed on the videotape, as Dr. Dubner/Dr. Prater noted in their report, casting doubt on those scores. As seen, claimant's answers displayed a keen insight into himself, his condition, and his experiences. He expressed his desires, things he would like to do, and friendships he would like to cultivate. Claimant's affect remained somewhat flat and sad throughout the assessment, but he did respond tearfully at appropriate times. He used appropriate gestures when answering questions, and used correct verbiage and a very advanced vocabulary. He also made eye contact with Dr. Prater when answering questions posed to him.

Furthermore, it was not established that claimant's limitations in social functioning as demonstrated by his inability to make friends, attend school, enter unfamiliar environments, maintain employment because he was overwhelmed, or his struggles in social settings were due to autism. A developmental disability cannot include handicapping conditions that are "solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder." Here, claimant's records documented a lengthy history of other psychiatric and medical conditions, as well as a family history of many issues, all of which better explained claimant's symptoms.

Years of records described claimant's severe anxiety and OCD. There were references in documents to psychotic episodes, depression, eating disorder, PTSD, non-epileptic seizures, mood disturbance, self-harm, passive suicidal ideations, and emotional issues. There were also references about family psychiatric histories, an alcoholic father, and, as claimant described, a "horrendous" home life where his dad and sister were "emotionally abusive" to him. As a child, claimant had severe anxiety,

so extreme that despite psychiatric and psychological therapy, he was hospitalized at age 12. Several psychiatrists and psychologists participated in claimant's hospital therapy and those records referenced anxiety and OCD. Records also documented claimant's mother's car accident which increased claimant's anxiety, and claimant's mother testified about claimant's alcoholic father. Claimant has other medical conditions that could be contributing to his psychological condition. Claimant has also been prescribed medications for depression for almost 25 years and currently takes several antidepressants. Claimant sitting on a couch for weeks with a blanket over his head was not a feature of autism. Claimant's eating disorder was not a feature of autism. Claimant seeing blood, large bugs, and a bleeding person in a tree outside his bedroom window was not a feature of autism. Dr. Cronin and Dr. Freeman attributing all of claimant's symptoms to autism was a stretch. Instead, Dr. du Verglas's/Dr. Rodriguez-Cortes's opinions that other diagnoses better explained claimant's condition and should be evaluated were fully supported by the record and made their opinions more persuasive than claimant's experts' opinions.

Dr. Cronin and Dr. Freeman were not dispassionate, unbiased experts. They discounted findings that showed claimant was not substantially disabled such as his high level of cognitive skills, keen insight, introspection, and advanced vocabulary. They gave claimant's mother's scores great weight, even though her answers were incompatible with how claimant presented on the videotape or as documented in the records and reports. They characterized claimant's speech and love of learning as being his "restricted, repetitive behaviors," despite the fact that his speech was fluid, he could easily change topics, and he asked clarifying questions as shown on the videotape. Their criticisms of "trainees" performing the evaluations were not persuasive as registered psychological associates may perform evaluations, and both Dr. Rodriquez-Cortes and Dr. Prater were supervised by licensed psychologists as

allowed by Business and Professions Code sections 2913 and 2914 and California Code of Regulations, title 16, sections 1387, 1391.1, 1391.3, 1391.5, and 1391.6. Further, Dr. Cronin and Dr. Freeman had no basis for their opinions that either registered psychological associate lacked the requisite training and experience to assess claimant. Further, they did not diagnose claimant with anxiety or OCD despite his numerous diagnoses of those conditions and his receiving treatment for them.

Dr. Freeman's and Dr. Cronin's criticism that Dr. Rodriquez-Cortes did not obtain sources of information other than from claimant was also not persuasive. As they even noted, claimant's mother is the only other source of information as claimant is not in school and has no others who could answer questions about him. Moreover, although Dr. Rodriquez-Cortes did not administer a formal adaptive functioning exam to claimant's mother, he did obtain a very detailed developmental history from her in which she provided information regarding claimant's adaptive abilities, which Dr. Freeman and Dr. Cronin referenced in their report. Dr. Rodriguez-Cortes also evaluated claimant on three separate occasions. However, to allay Dr. Freeman's and Dr. Cronin's concerns, WRC had claimant undergo a "quality of functioning" assessment with Dr. Dubner/Dr. Prater, which was observed by four other individuals off camera. That assessment, like Dr. du Verglas/Dr. Rodriguez's report, as noted above, supported WRC's determination.

In sum, the records indicated claimant was high functioning, clearly met the severity level 1 criteria, did not have substantial disabilities in three of the seven required categories, and his condition was better explained by his other non-qualifying psychiatric conditions, including those Dr du Verglas and Dr. Rodriguez-Cortes recommended should be evaluated to rule out. On balance, the opinions rendered by Dr. du Verglas, Dr. Rodriguez-Cortes, Dr. Dubner, Dr. Prater and Dr. Gayles, are

accepted over those espoused by Dr. Cronin and Dr. Freeman and supported WRC's finding that claimant is not eligible for regional center services.

ORDER

Claimant's appeal from WRC's determination that he is not eligible for regional center services is denied. WRC's determination that he is not eligible for regional center services is affirmed.

DATE:

Mary Agnes Matyszewski
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.