BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

SAN ANDREAS REGIONAL CENTER, Service Agency.

DDS No. CS0029999

OAH No. 2025090204

DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings (OAH), served as the hearing officer for this matter on August 12, 13, and 21, 2026, by videoconference.

Claimant was represented by attorney Damien B. Troutman. Claimant appeared briefly on the first day of hearing and verbally confirmed her authorization for attorney Troutman to represent her in this matter, but she did not otherwise attend the hearing.

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

The hearing was continued and the record remained open until September 11, 2026, for the parties to submit written closing briefs and optional responses. These were received and admitted as Exhibit 15 (SARC's closing),[1] Exhibit C15 (claimant's closing), and Exhibit C16 (claimant's response). SARC did not submit a response.

The matter was submitted for decision on September 11, 2026.

ISSUE

Is claimant eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) (Welf. & Inst. Code, § 4500 et seq.)[2] on the ground that she is substantially disabled by autism?

FACTUAL FINDINGS

Introduction and Dispute Regarding the Issue to Be Decided

1. Claimant is 28 years old and was born in September 1997. She lives with her parents and younger sister. Claimant is not conserved.

2. In 2014, when claimant was 16 years old, she asked SARC to evaluate her eligibility for regional center services under the category of autism. As described in more detail below, SARC assessed claimant and determined that she was not eligible.

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[1] SARC's closing brief was submitted late, but it was admitted and considered.

[2] All statutory references are to the Welfare and Institutions Code.

3. In January 2025, at age 27, claimant applied again to SARC for regional center services, seeking eligibility under the category of autism (now referred to as Autism Spectrum Disorder or ASD). Claimant provided a January 2025 letter from her treating psychiatrist and later provided a May 2025 report from her behavior analyst.

4. On June 12, 2025, SARC issued a denial letter signed by intake manager Janet Juarez. This letter stated that in July 2014, SARC had determined that claimant did not have an eligible condition, and that after reviewing the additional information, SARC continued to find that claimant "does not meet the criteria for ASD and thus we cannot approve her for a redetermination assessment." The letter stated that no new information had been provided regarding claimant's development prior to the age of 18, and that her "behaviors continue to be best described as mental health in nature and not due to Autism."

5. Claimant filed an appeal challenging the denial of eligibility, and this matter was referred to OAH.

6. During the course of the appeal, claimant provided further information to SARC, including additional letters and reports from her treating providers.

7. On October 2, 2025, SARC issued a second denial letter signed by its representative, James Elliott. This letter listed the additional information reviewed by SARC and stated it was "affirming the denial decision regarding [claimant's] eligibility." The letter conceded that claimant had been diagnosed with ASD, an eligible condition, in 2006. It then went on to discuss the second component of the Lanterman Act eligibility criteria, which requires significant functional limitations in three or more areas of daily living. The letter discussed specific aspects of claimant's adaptive functioning skills and concluded they were not sufficiently impaired to meet eligibility.

Lastly, the letter invited claimant "to proceed with your scheduled hearing should you not agree with this decision," without stating that the hearing would be limited to the question of reassessment.

8. Claimant subsequently retained an attorney, who filed a notice of representation with OAH in December 2025.

9. At the beginning of the hearing, the hearing officer discussed with the parties their contentions regarding the scope of claimant's appeal, as set forth in their position statements filed two business days before the hearing. SARC contends that this appeal is limited to the question of whether SARC must provide another eligibility determination assessment and does not extend to the ultimate question of eligibility. Claimant argued that SARC's October 2025 denial letter, which analyzed the question of claimant's eligibility on the merits, and invited claimant to proceed to hearing, put the ultimate question of eligibility at issue.

10. The hearing officer agreed with claimant's position and ruled at hearing that the issue in this appeal is whether claimant is eligible for regional center services.

Evidence Reviewed in this Appeal, and the Parties' Contentions

11. As a result of the ruling on the scope of the appeal, the hearing officer granted SARC's request to set another day of hearing (August 21), so that SARC could present its psychologist as a witness to address the question of eligibility.

12. Three witnesses testified for claimant: an evaluating psychologist, claimant's behavior analyst, and claimant's mother. In addition to recent evaluation and assessment reports from the psychologist and behavior analyst, claimant submitted prior reports and other documents. SARC's representative did not object to

expert opinion testimony from claimant's evaluating psychologist and behavior analyst and did not object to claimant's documents.

13. SARC submitted documents but did not offer any witnesses. On the third day of hearing, SARC's psychologist was unexpectedly unavailable due to a funeral. SARC did not seek another continuance so that this witness, or any other, could testify.

14. Claimant contends that she is eligible for regional center services due to ASD, which arose prior to the age of 18, is expected to continue indefinitely, and constitutes a substantial disability for her by causing significant functional impairments in four areas of major life activity: self-care, self-direction, capacity for independent living, and economic self-sufficiency.

15. SARC makes several alternative arguments in its closing brief.

SARC emphasizes the determination of its assessment team in 2014 that claimant did not have autism.

SARC objects that the report of claimant's evaluating psychologist and the supplemental report of the behavior analyst were not provided prior to hearing, and that allowing admission of these witnesses' testimony and reports as to eligibility is unfairly prejudicial. These objections are overruled. There is no prejudice to SARC, and the appellate decision SARC cites regarding civil discovery is inapplicable. Claimant complied with the statutory pre-hearing disclosure requirements set forth in Welfare and Institutions Code section 4712, subdivision (d)(3). SARC did not object to claimant's documents and witnesses at hearing and cross-examined those witnesses as to their opinions and their bases. SARC sought and received additional time between the second and third days of hearing, so that its psychologist could review and opine on claimant's eligibility claim. When SARC's psychologist was unexpectedly available,

SARC offered an email from the psychologist, and did not seek any further continuance.

SARC contends that the Lanterman Act requires that the claimant's significant functional limitations must arise prior to the age of 18, and that claimant has not shown such limitations.

SARC also makes an argument related to "autistic burnout" and contends claimant's limitations are not likely to continue indefinitely.

Applicable Eligibility and Diagnostic Criteria

16. The Lanterman Act provides for assistance to individuals with five specified developmental disabilities: intellectual disability, cerebral palsy, epilepsy, autism, and the "fifth category" of disabling conditions that are closely related to an intellectual disability or that require treatment similar to that required for an individual with an intellectual disability. (§ 4512, subd. (a)(1); Cal. Code Regs., tit. 17, § 54000.)

17. For each of the above, the condition must begin before the age of 18, must be expected to continue indefinitely, and must be a substantial disability for the person. (§ 4512, subd. (a)(1).) "Substantial disability" means significant functional limitations, as appropriate to a person's age, in three or more areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

18. Eligible developmental disabilities do not include disabling conditions that are solely psychiatric disorders, solely learning disabilities, or solely physical in nature. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

19. Regional centers use the diagnostic criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (the DSM), in determining eligibility under the Lanterman Act based on a claim of autism. The current version is the Fifth Edition Text Revision, or DSM-5-TR, published in 2022. Previous versions were used by clinicians who evaluated claimant at earlier times: the DSM-IV-TR (published in 2000) and DSM-5 (published in 2013). The diagnosis of ASD in the DSM-5 and DSM-5-TR encompasses a variety of disorders that were separately categorized in the DSM's Fourth Edition.

20. The diagnostic criteria for ASD in the DSM-5-TR are:

> A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):
>
> 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
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> 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse

response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual development disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, social communication should be below that expected for general developmental level.

(DSM-5-TR at pp. 56-57.)

The DSM-5-TR diagnostic criteria for ASD include a note stating: "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder." (*Id.* at p. 57.) Guidance is also provided for clinicians to designate a severity level for social communication impairments and for

restricted, repetitive behaviors. Level 3 means the individual requires very substantial support; Level 2 means the individual requires substantial support; and Level 1 means the individual requires support. (*Id.* at pp. 57-59.)

The DSM-5-TR's discussion of "diagnostic features" (*Id.* at pp. 60-62) explains that the core diagnostic features are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Further, the manifestations of the disorder vary based on the severity of the autistic condition, developmental level, chronological age, and possibly gender, hence the use of the term "spectrum." Individuals without cognitive or language impairment may have more subtle manifestations of deficits and may be making great efforts to mask these deficits. The discussion also explains that diagnoses are most valid and reliable when based on multiple sources of information, including clinician's observations, caregiver history, and self-report. It emphasizes that standardized behavioral diagnostic instruments are available but that "the diagnosis remains a clinical one, taking all available information into account, and is not solely dictated by the score on a particular questionnaire or observation measure." (*Id.* at p. 62.)

Claimant's History and Evaluations Through 2013 (Age 15)

21. Claimant's parents were first concerned with her development at about 18 months, due to her rigidity to rules, difficulty with transitions, repetitive play, and engaging in little to no pretend play.

22. In June 2005, when claimant was seven, psychiatrist Rebecca A. Powers, M.D., diagnosed her with bipolar disorder, attention-deficit/hyperactivity disorder (ADHD), and possible Asperger's disorder.

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23. In November 2006, when claimant was nine, she was evaluated at the Kaiser Autism Spectrum Disorders Center, by a psychology assistant and a child and adolescent psychiatrist. She was referred for evaluation for diagnostic clarity and due to social difficulties and behavioral issues. The Kaiser evaluators reviewed claimant's records, conducted clinical interviews with claimant and her parents, and administered assessment instruments. In addition to the developmental concerns described in Factual Finding 21, the evaluators noted that claimant had been hospitalized twice in 2006 after uncontrollable meltdowns where she hit her parents and threw things.

The evaluators attempted to administer the ADOS (Autism Diagnostic Observation Schedule), a semi-structured standardized assessment instrument, but claimant demonstrated anxiety and tantrum behaviors and the ADOS could not be completed. Instead, the evaluators gathered information by conducting an unstructured play observation session with claimant and her parents.

The ABAS-II (Adaptive Behavioral Assessment Scale - Second Edition) showed significant deficits in adaptive behaviors across many assessed domains. The evaluators noted: "despite a lack of cognitive impairments, her daily functioning is at the level of a younger child in many areas. Such a pattern is typical of children with high-functioning autistic spectrum disorders."

Language abilities: Claimant had excellent receptive language but was very concrete and regularly got confused with interpreting abstract terms. She used sentences in largely correct fashion, with very precise grammar, vocabulary, and pronouns (and would correct others' usage). She was fairly mechanical in pitch and tone. She sometimes used very formal speech ("I like that, I exclaim!"). Claimant did not engage in truly reciprocal conversation.

Reciprocal and social interactions: The evaluators noted claimant had unusual or inconsistent eye contact and flat facial expressions. She often stood too close when interacting and sometimes turned her body away from the other person. She had always shown interest in other children but had difficulties reading others' social cues and understanding subtle rules of socialization, such as being overly affectionate and not able to tell when others are not interested, monopolizing play with peers, and insisting other children follow her play interests.

Routines and behaviors: Claimant had difficulty self-organizing her play, had not started to engage in pretend play, and lined up toys instead of functionally playing with them. She was bothered by loud noises. She was rigid about routines (diet, schedule, placement of objects, things she said, clothes, singing the same repertoire of songs over and over in same order). She had meltdowns at least once a day, typically triggered by frustration and unmet expectations.

The Kaiser evaluators provided DSM-IV diagnoses of Asperger's Disorder, and bipolar disorder "by history." The evaluators summarized claimant as presenting with difficulties consistent with an autism spectrum disorder, noting that although she has good cognitive and academic skills, she struggles adaptively in several domains. They found she met the diagnostic criteria for Asperger's Disorder, with marked impairments in use of multiple nonverbal behaviors, failure to develop appropriate peer relationships, lack of social or emotional reciprocity, ability to initiate or sustain conversation with others, and inflexible adherence to specific nonfunctional routines or rituals. They concluded: "Although [claimant] was previously diagnosed with Bipolar Disorder, at present the best diagnosis that explains [claimant's] overall symptomalogical profile is Asperger's Disorder."

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24. As of fall 2006, claimant was in fourth grade and had an individualized education program (IEP) for special education services under "emotional disturbance."

In October 2006, treating psychiatrist Dr. Powers wrote a letter to claimant's school psychologist, recommending accommodations for education and noting diagnoses of ADHD, bipolar disorder, and Pervasive Developmental Disorder Not Otherwise Specified. Dr. Powers opined that these disorders affected claimant's school and social performance greatly.

In November 2006, JoAnn Brei, L.C.S.W., conducted a mental health assessment for the school district, and recommended special education services, therapy, and collateral services. She noted issues that included: physical aggression, problems maintaining boundaries with others, difficulty with transitions, low frustration tolerance, mood changes, poor organizational skills, difficulty concentrating, easily distracted, and low self-esteem. At age nine, claimant still could not tie her shoes. She was a "rigid child" from a very early age. In second grade she had anxiety and difficulties socializing. In third grade the school provided claimant with a social skills/friendship group to help her with peer relations. She did not do well if her time was not structured, due to frustration and meltdowns. In fourth grade, her social behavior continued to be an issue, with severe outbursts at home.

25. In July 2013, when claimant was 15, Michelle Swartz, M.F.T., conducted a mental health assessment for the school district. Claimant was referred for assessment due to ongoing academic and emotional challenges, high anxiety, recent onset of depression, and ongoing difficulties with sensory processing, self-care, and independence. Her teacher reported that when claimant was upset at school, she yelled and slammed doors but could calm down and resume activity if given a break. Claimant had been receiving weekly individual counseling at school for three years.

The evaluator observed that claimant was socially motivated with several friends but had difficulties recognizing others' perspectives.

SARC's 2014 Eligibility Assessment and Denial (Age 16)

26. Claimant applied for regional center eligibility in 2014 at age 16.

27. In March 2014, claimant and her mother met with a SARC intake counselor and psychologist Jennifer Park-Way, Ph.D., for an intake social assessment. The assessment report described claimant's current functioning. Claimant was verbally advanced but mumbled when nervous or upset. When upset, claimant had problems communicating and would bang chairs, hit walls, and lash out at others. Claimant could dress herself but was limited in her choices of clothing. Claimant did not trust herself to know if she was truly dry after washing, only showered once a week because of not wanting to be wet, and insisted that her mother blow dry her body afterwards. She could use a toothbrush but did not do a good job and recently required thousands of dollars' worth of dental work. Claimant was medication compliant but could not fill her medication box or reorder prescriptions. She was sometimes able to cook or prepare food but sensory issues got in the way. She did some household chores with much prompting. She saved money to buy Pokémon cards.

28. SARC referred claimant for evaluation by its vendored psychologist Dudley G. Luke, Ph.D., who evaluated claimant in April 2014 and issued a report in June 2014. Dr. Luke met with claimant and her mother once and reviewed records. In discussing prior assessments from 2006, Dr. Luke noted that the Kaiser evaluators were not able to complete the ADOS with claimant but had assigned a diagnosis of Asperger's Disorder. He also noted the school district found the Asperger's Syndrome Diagnostic Scale (ASDS) yielded a result of "very unlikely" (quotient 69) for Asperger's.

The adaptive behavior assessment scales completed in connection with the Kaiser evaluation and the school evaluation yielded different results, with lower functioning scores reported in the Kaiser evaluation. The school psychologist had noted the discrepancy and wrote: "At school, she may be monitoring and modulating her social skills so that skills are falling in the unlikely range. This is due, in part, to motivation to fit in and intelligence."

Dr. Luke attempted to administer the ADOS-2, but claimant refused to participate, stating she did not want to do it and leaving the room. Dr. Luke also noted that when he asked claimant how school was that day, she appeared angry and said that was a "personal" question and he was not her therapist and left the room.

Dr. Luke did not assign any DSM-5 diagnosis for claimant. He concluded:

> Although [claimant] exhibited some behaviors that are symptomatic of ASD, such as social awkwardness, failure to develop peer relationships, inflexibility, poor personal boundaries, restrictive interests, and low frustration tolerance and tantrums, but these behaviors are not exclusive to ASD and may be better explained for and/or additional explained by some of the other disorders, particularly ODD [Oppositional Defiant Disorder] and Bi-Polar Disorder. Her refusal to participate in the ADOS-2 was likely motivated by ODD rather than ASD.

Dr. Luke referenced the 2006 note from the school psychologist about the discrepancy in adaptive functioning ratings, but Dr. Luke interpreted this as suggesting ODD rather than ASD. He disputed the Kaiser ASD diagnosis because there were no ADOS results.

Dr. Luke concluded that he could not assign a DSM-V diagnosis of ASD due to limited information and the lack of the ADOS and wrote that "symptoms of ASD are likely secondary to Mood Disorder, ODD, and ADHD which are primary, and likely explain for substantially more of her maladaptive behaviors than ASD."

29. In July 2014, SARC's psychologist, Dr. Park-Way, wrote an eligibility determination summary based on the intake social assessment, Dr. Luke's report, and ratings on ABAS forms completed by claimant, her mother, and her school therapist. The therapist rated claimant in the Low Average to Average range overall, except for Self-Care which was in the impaired range. Claimant's mother rated claimant significantly lower, for an overall general adaptive composite score in the impaired range. Claimant's self-ratings were in the middle with an overall borderline score.

Dr. Park-Way noted that claimant "has a significant history of rigidities, difficulty with transitions, poor boundaries with others, and poor reciprocity that increased in her second and third grade year." She also noted claimant's subsequent psychiatric hospitalizations. Dr. Park-Way concluded that claimant had some behaviors that can be associated with autism (failure to develop peer relationships, stereotypical behaviors of excessive adherence to routine, sensitive to sensory input), but that she did not meet DSM-5 criteria for ASD or the DSM-IV criteria for Autistic Disorder. Dr. Park-Way found that claimant's inappropriate behaviors appeared to be driven by poor emotional regulation or bipolar disorder rather than ASD.

30. In September 2014, SARC denied eligibility based on this determination. OAH records reflect that claimant filed an appeal at that time but then withdrew her request for hearing without prejudice.

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October 2014 Psychiatric Evaluation (Age 17)

31. In October 2014, when claimant was age 17, her treating psychiatrist Dr. Powers wrote a psychiatric re-evaluation report to achieve diagnostic clarity due to ongoing behavioral challenges and functional impairment, and for treatment planning. Dr. Powers found claimant had persistent deficits in social communication, emotional reciprocity, and adaptive functioning, as well as restricted, repetitive behaviors and sensory sensitivities, and provided strong support for an ASD Level 2 diagnosis. The diagnostic results list included ODD and bipolar disorder in addition to ASD. However, the narrative written by Dr. Powers described symptoms that can be observed in bipolar disorder, but then found they were ultimately attributable to claimant's ASD:

> The grandiosity part of bipolar has to do with people doing things just right. In fact, the irritable moods and any other kind of violence had to do with her autistic disorder since it is usually related to misunderstandings or people not doing things the way she honestly believes they should be done.
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> The grandiosity part of hypomania/mania was classic of a child on the spectrum.
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> Flight of ideas was endorsed as a symptom, because "her mind is mixed up" and this contributed to difficulty sleeping. Other than that, she has good judgment except

when related to her autistic disorder. She really doesn't meet the criteria otherwise.

. . .

Therefore, the bipolar features of her mood are really secondary to the autistic disorder. Because of her autism, she has a need for things being in place according to her thinking, her inflexibility, and difficulty with transition. Her depressed mood is secondary to her need for things to be in order and her inflexibility as well.

Claimant's 2025 Application to SARC for Regional Center Eligibility

32. As described in Factual Finding 3, claimant re-applied to SARC in 2025. Claimant provided a letter from her current treating psychiatrist, Meredith Cait Brady, M.D., dated January 29, 2025:

> [Claimant] is my patient at [Palo Alto Medical Foundation]. She has a diagnosis of autism spectrum disorder. I strongly recommend she link with Regional Center for supportive resources/services. As a child, she was diagnosed with both bipolar disorder and autism spectrum disorder. It is my strong opinion that she does NOT have bipolar disorder and has never exhibited manic or hypomanic episodes in the past. Suspect her past mood symptoms stemmed from irritability and low frustration tolerance in the context of autism spectrum disorder.

33. Claimant also provided an assessment report dated May 28, 2025, from her behavior analyst, which assessed claimant's functional living skills in multiple areas.

34. SARC issued denial letters in June 2025 and October 2025, as described in Factual Findings 4 and 7.

2026 Neuropsychological Evaluation by Dr. Bradley

35. In 2026, Elise B. Bradley, Ph.D., conducted a neuropsychological evaluation of claimant. Dr. Bradley wrote a comprehensive report and testified at hearing credibly and consistently with her report. Dr. Bradley is a licensed clinical psychologist with many years of experience conducting psychological assessments. She currently has a private practice focusing on assessment of adolescents and adults for learning differences and neurodiversity, among other issues. Dr. Bradley previously worked as a clinical neuropsychologist and professor at Vanderbilt University.

36. On four dates in February and March 2026, Dr. Bradley met with claimant by telehealth video for a clinical interview (90 minutes), neurobehavioral status examination (60 minutes), and administration of psychological assessments (more than five hours over three days). She also reviewed claimant's prior records and evaluations. Dr. Bradley conducted separate collateral interviews with claimant's mother and father, behavior analyst Chau, and treating psychiatrist Dr. Brady.

37. Dr. Bradley concluded that claimant meets the diagnostic criteria for ASD, Level 2 (requiring substantial support), without accompanying intellectual impairment or language impairment. She found claimant had persistent deficits in criteria for social-emotional reciprocity (abnormal social approach, reduced sharing of interests, reduced sharing of emotions/affect); nonverbal communication for social interaction (abnormalities in use and understanding of affect); and developing and maintaining

relationships (difficulties making friends, difficulties adjusting behavior to suit context, deficits in developing and maintaining developmentally appropriate relationships). Dr. Bradley also found claimant met the criteria for restricted, repetitive behavior: stereotyped or repetitive use of objects; excessive adherence to routines, excessive resistance to change, and rigid thinking; highly restricted, fixated interests; and sensory hypersensitivity and preoccupation with texture or touch.

Dr. Bradley persuasively described an overall clinical picture of claimant that is consistent with the DSM-5-TR diagnostic criteria for ASD based on her observations of claimant, neurocognitive and neuropsychological assessment data, ratings of adaptive function, and consistent information from historical and current collateral sources. Her summary of the diagnostic impressions noted that claimant's early developmental history was significant for longstanding vulnerabilities in social communication and reciprocity, that co-occurred with social motivation and capacity for engagement with select individuals. Claimant also showed longstanding repetitive behaviors and rigidity. Neurocognitive data revealed relative weaknesses in aspects of processing speed and executive control that are consistent with patterns observed in ASD.

Dr. Bradley also diagnosed major depressive disorder, recurrent, mild; generalized anxiety disorder; and other specified ADHD. Dr. Bradley did not find that claimant met criteria for bipolar disorder, and does not believe claimant ever did, due to the lack of evidence for clear and distinct episodes of mania or hypomania.

38. Dr. Bradley explained that her findings were consistent with the observations documented by claimant's behavior analyst and job coach (Chau), and claimant's psychiatrist (Dr. Brady). Dr. Brady had not observed symptoms of mania or hypomania, and conceptualized claimant's emotionally dysregulated behavior as consistent with ASD. Chau documented that claimant's repetitive behaviors, cognitive

rigidity, and sensory sensitivities associated with autism consistently interfere with her ability to establish and maintain employment and attend to activities of daily living. Chau also recorded that claimant is embarrassed by her behaviors and makes efforts to mask them while in public. Dr. Bradley opined that claimant's disruptive behavior "stems from emotional dysregulation fueled by difficulties communicating when emotionally distressed, overwhelm with change or a new environment, sensory overload, and executive dysfunction," which she described as a pattern characteristic of autism and not suggestive of willful anger, aggression, or defiance.

39. Dr. Bradley reviewed the 2014 evaluation by Dr. Luke, and disagreed with it, explaining that Dr. Luke's conclusions were not persuasive for several reasons.

(a) Dr. Luke identified core features of ASD demonstrated by claimant but did not assign an ASD diagnosis. He attributed claimant's behaviors to other psychiatric diagnoses such as ODD and bipolar disorder, but he did not actually provide direct evidence of criteria to support those diagnoses. Dr. Luke's report also did not address that claimant's behavior resembled a common autistic pattern in which emotional and behavioral dysregulation emerge in the home setting after prolonged effortful compensation across the school day. Dr. Bradley explained that the literature notes that ODD-like behaviors in autistic youth may occur and often arise from core autistic processes including rigidity, communication difficulties, and sensory overload. Dr. Bradley also disputed Dr. Luke's attribution of claimant's features to bipolar disorder, noting that claimant's history and data did not provide clear evidence of the diagnostic criteria to support a bipolar diagnosis, and emphasized that pediatric bipolar disorder is "exceptionally uncommon" and warrants particular scrutiny. Moreover, claimant's former treating psychiatrist, Dr. Powers, ultimately described claimant's bipolar-like symptoms as being secondary to ASD. (Factual Finding 31.)

(b) Dr. Luke relied on a prior school assessment measure that stated an Asperger's profile was "very unlikely." However, Dr. Bradley persuasively explained that the lack of school collateral support should not be interpreted as affirmative evidence against ASD. Teacher observations are valuable but are limited to one context.

Dr. Bradley discussed in her report and testimony that in recent years, research and studies have developed a more nuanced understanding of how ASD manifests in girls and women, especially if they are verbally fluent and intelligent. Many autistic girls may camouflage social-communication differences through imitation, rehearsed social scripts, suppression of visible distress, and other learned compensatory strategies. This can result in a school presentation that appears adequate but masks substantial efforts and functional cost. Dr. Bradley explained that studies show that teachers frequently underreport social challenges in girls, and rate 50 percent of autistic girls as having no challenges at school despite clinical diagnoses of autism. She also noted that many measures were originally normed on symptom presentation in boys and men and are less sensitive to ASD in females.

(c) Dr. Luke found that claimant exhibited no or mild deficits in some areas of social communication or nonverbal behaviors during his observation of claimant. However, Dr. Bradley emphasized that relying disproportionately on presentation of functioning in one setting does not consider the full ASD diagnostic criteria, which indicate symptoms may be currently present or were present in developmental history. Dr. Luke also stated he could not diagnose ASD without the ADOS assessment, and he interpreted claimant not agreeing to the ADOS as being "refusal." He did not document consideration that this avoidance behavior could also be explained by cognitive or behavioral rigidity, which is common in ASD.

Dr. Bradley persuasively opined that the ADOS is an assessment tool that can contribute to a comprehensive evaluation, but that it is not the only method for evaluating the clinical profile of ASD, and the absence of ADOS administration is not sufficient to exclude an ASD diagnosis. Dr. Bradley did not administer the ADOS, but she explained that she gathered the same information via her clinical interview.

40. Dr. Bradley analyzed the Lanterman Act eligibility criteria and opined that claimant has significant functional limitations in four areas of major life activity: self-care, self-direction, capacity for independent living, and economic self-sufficiency. Claimant's limitations are longstanding and manifested before age 18. Dr. Bradley also noted that it is common for symptoms of ASD to become more apparent as a person grows up, as the demands of the person's environment exceed their ability to cope or as supports are withdrawn.

(a) Claimant has significant and longstanding impairments in self-care, personal hygiene, and oral health, which are not attributable to noncompliance or lack of motivation. Instead, they are attributable to severe sensory processing dysfunction and anxiety associated with ASD. Claimant cannot tolerate getting wet and does not feel dry afterwards. She cannot bathe regularly despite her parents being very involved in her self-care. Claimant cannot tolerate the sensory elements of brushing her teeth, including the taste of toothpaste and the sensation of brushing. She has already had at least 10 teeth extracted due to lack of oral hygiene and has been told by her dentist she will lose the rest of her teeth, but she cannot bring herself to do it.

(b) Claimant is significantly impaired in the area of self-direction, due to her sensory sensitivities, emotional dysregulation, cognitive and behavioral rigidity, and executive functioning inefficiencies. She experiences a great deal of sensory overwhelm and does not have the mental flexibility to adapt to changing

circumstances. When she is dysregulated, she cannot perform at her baseline. Claimant is impaired in self making choices, completing tasks, and following routines. She requires substantial external scaffolding, guidance, and support, and relies heavily on her family for basic daily activities, managing her daily routine, and de-escalating when she is emotionally dysregulated. Her behavior analyst Chau helps claimant with basic communication with potential employers and community providers such as therapists.

(c) Claimant cannot live independently. She is dependent on her family for hygiene assistance, meal access, health management, and community navigation. When she is regulated, she can perform certain tasks that become impossible when she experiences sensory overwhelm or emotional dysregulation.

(d) Claimant has made numerous attempts at employment, none of which were successful long term. Each was seriously affected by her sensory issues and executive functioning impairments due to ASD. Her longest employment was for about 18 months at Safeway, and she only maintained it at considerable psychological cost and with support. Claimant's role as a Pokémon judge (see Factual Finding 42 below) is sustained solely due to flexibility and numerous accommodations.

Claimant's Additional Evidence

SAMANTHA CHAU

41. Samantha Chau, M.S., B.C.B.A., of EvoLibri Consulting, is claimant's behavior analyst and job coach. Chau testified credibly and persuasively at hearing, consistently with the reports she wrote in May 2025 and August 2026. Chau has a master's degree in psychology. She has been a board-certified behavior analyst since 2020, and prior to that had six years of experience as a registered behavior therapist. Chau is the director of individual services at EvoLibri Consulting, conducts functional

behavior assessments regularly, and works with teens and adults. Chau has worked with claimant since January 2021 as her behavior analyst and coach.

42. Chau's May 2025 report described claimant's functional skills in several areas and provided the results from an Assessment of Functional Living Skills (AFLS). The AFLS assessment shows deficits in self-management, dressing, and nighttime routines, and profound deficits in grooming and bathing. Claimant's sensory issues prevent her from practicing oral hygiene and bathing. She has had skin infections due to not bathing. Claimant attempted several jobs but could not complete training or work due to sensory issues and other problems. Claimant is involved with the Pokémon community and at that time she could travel to attend Pokémon events. Claimant has a driver's license but cannot drive when emotionally dysregulated. She cannot take public transportation. Claimant struggles with cognitive flexibility, which prevents her from managing a regular routine. She is commonly emotionally dysregulated when performing non-preferred tasks, and this may result in refusal, perseveration, verbal aggression, property damage, and uncontrollable crying. Claimant makes a considerable effort to mask those behaviors in public.

43. Chau wrote an addendum report in August 2026 to document claimant's increased impairments in some areas, and to more directly address the Lanterman Act areas of major life activity. She also discussed these in her testimony. In Chau's professional opinion, claimant's ASD is substantially disabling in the areas of self-care, self-direction, capacity for independent living, and economic self-sufficiency.

44. Since late 2025, claimant's functional skills have declined in some areas. For example, she previously could travel alone to attend Pokémon events (with support from others) but has increasingly been unable to do so with the sensory demands of navigating the community being too overwhelming. In December 2025,

claimant had to discontinue therapy with Bagley (see Factual Finding 49), because she could not tolerate the odors of a veterinary clinic located in the same building as the therapy office. Claimant has also increasingly struggled to tolerate the smells of cooking in her family's home kitchen. Claimant's ability to drive has become very inconsistent due to autism-related anxiety and sensory overload. When regulated, she was able to drive familiar routes (not on the freeway) but now is unable to drive six out of seven days. In June 2026, claimant attempted to pursue an opportunity to move into a one-bedroom cottage near her family home, but the opportunity was retracted due to concerns over claimant's extreme auditory sensitivity and nearby construction.

45. Chau is providing support to claimant in unscheduled crisis telephone calls on a regular basis, to help her with problem-solving around sensory overwhelm, emotional dysregulation and panic responses, and coaching on environmental accommodations. Claimant requires real-time guidance to navigate everyday situations that become overwhelming due to her autism.

46. Claimant attended some community college classes but stopped in 2023. She struggled with executive functioning and was overwhelmed.

47. Chau described claimant's repeated problems securing and maintaining employment, despite support. Claimant is interested in children, and she was hired to be an assistant at Happy Hollow, a local theme park, but could not start work due to problems getting dress code accommodations (she was unable to wear the required uniform due to sensory issues). Claimant was hired as a part-time seasonal clerk at a children's clothing store and completed only a few shifts because the store provoked claustrophobia and sensory overwhelm. She was hired as a school crossing guard but had problems feeling overwhelmed for the children's safety, problems with adults not following her instructions, and physical issues standing. Claimant was hired to be a

ride attendant at Great America theme park, but could not complete the training, fleeing in a state of dysregulation during training safety videos about children being hurt or killed. Claimant worked at a Safeway store for about 18 months but only with great difficulty and support.

48. On cross-examination, Chau was asked whether claimant's decline in ability to access some skills could be what some call "autistic burnout," and she agreed. In SARC's closing brief, SARC argued that this is an ameliorable situation that improves with intervention, and thus that claimant's limitations are likely to continue indefinitely. This argument is rejected—there was no definition of the term autistic burnout, no explanation about what it signifies, and no evidence was received to suggest that claimant's limitations are not likely to continue indefinitely.

ANGELIQUE BAGLEY

49. Angelique Bagley, L.M.F.T., wrote a letter in connection with this appeal. It is undated, but from context appears to have been written in September 2025. Bagley is the Clinical Director at EvoLibri Consulting and had been involved in claimant's care for several years. Bagley wrote that claimant's ASD is "at the forefront of the issues that we help her manage." She discussed the DSM-5-TR diagnostic criteria for ASD, and provided her observations regarding claimant, summarized below.

- Claimant has a limited range of social emotional reciprocity. She has worked very hard on social communication over the years and is able to mask this area better than others. She is able to carry on shared conversation for a short time and have some normal back and forth with familiar people or those who have something in common with her. She has a reduced sharing of interests and emotions in general.

- Eye contact can be very difficult. Claimant finds sarcasm and jokes difficult to pick up, and if she uses sarcasm or jokes they may not suit the context.

- Claimant has interest in peers but only if they share her same perseverative interests. She has difficulty developing, maintaining, and understanding relationships of all kinds, and sensory issues can be limiting. She has difficulty adjusting behavior and verbalizations to suit the context.

- Echolalia, idiosyncratic phrases and self-injurious behaviors (hitting her own head with fist or palm) have been observed, especially when distressed.

- Claimant experiences a lot of discomfort with changes in her environment or routine (or that of her family). Small changes cause a lot of distress, despite her working on being flexible to changes in routine. This impacts her ability to carry on with the rest of the day or to sleep.

- Claimant has highly restricted interests (e.g., Pokémon) but has been able to find others with the same interests.

- Claimant is hypersensitive to sounds, textures, temperature, light, and pain. She does not brush teeth due to the toothpaste texture; does not like the feeling of being wet so does not bathe or wash her hair; and is unable to wear pants, only shorts. Sensory issues prevent her from attending to daily living skills and obtain employment. The more pressure claimant feels to push past these sensory issues, the more she shuts down or is likely to experience an emotional meltdown.

Bagley concluded: "I understand that she also has a Bipolar diagnosis. I have not seen or heard any symptoms of this diagnosis in our agency's time with [claimant]. I feel

that [claimant] meets the criteria for autism and this is her primary diagnosis for which she seeks treatment."

CLAIMANT'S MOTHER

50. Claimant's mother testified at length regarding claimant's symptoms, behaviors, and functional abilities. Claimant's mother also provided contemporaneous emails between herself and claimant's various providers from 2014 to 2025, describing claimant's functional limitations. The testimony of claimant's mother was credible, and consistent with the documentary evidence and the opinions of Dr. Bradley and Chau.

51. Claimant's mother credibly described claimant's functional limitations as longstanding and originating before the age of 18. For example, claimant's sensory issues with the feeling of wetness existed since childhood, and have prevented her from bathing regularly since about seventh grade. This struggle with hygiene persisted despite therapeutic interventions by providers and claimant's parents. Claimant's aversion to the feel of clothing textures and tags means that she wears the same shorts-and-T-shirt outfit regardless of weather (including on a trip to the snow). Claimant cannot prepare food reliably—she cannot make a sandwich and can complete only some of the steps of preparing macaroni and cheese without assistance. Her extreme aversion to cooking odors has caused the family to resort to cooking food in a crockpot in the garage. Cognitive rigidity has caused claimant to stop working with providers, such as a nutritionist, and has interfered with her eating for as long as her mother can recall. Claimant's problems with executive functioning skills shutting down during sensory overload have been a feature all her life. As claimant has gotten older and her parents direct her less and ask her to make more decisions, she has shut down more frequently. Claimant does not pay her own bills.

52. Even when claimant was able to travel to Pokémon events, she required a travel companion or assistance from trained airport staff, and several times became so upset while traveling she had to seek treatment at the emergency room or from airport paramedics. Claimant began working toward getting her driver's license when she was age 16, but did not succeed until she was 23. However, she is not able to drive regularly.

53. Claimant worked for about 18 months at Safeway, holding on to the job "by the skin of her teeth" with enormous assistance from her mother and Chau. Claimant was repeatedly reprimanded for inability to follow conflicting, poorly defined, or multi-step instructions. She was overwhelmed and eventually told by her manager she should consider quitting, which she did. Claimant frequently returned home from the job in a state of emotional distress due to its sensory and emotional regulation demands.

SARC's Document Review in August 2026

54. SARC provided an email exchange between its representative and psychologist Azelin A. Ellis, Psy.D. On July 29, 2026, SARC's representative provided Dr. Ellis further (unspecified) documents received from claimant's attorney and soliciting her opinion. On August 19, 2026, Dr. Ellis responded:

> From what I reviewed, I do not see a reason to offer a new intake. She was thoroughly evaluated as a child. SARC saw her at age 16 and ruled out Autism. She has a high IQ score and achievement scores mirror this, so no concern for Learning. She is described as demonstrating a strength in social pragmatics and noted to have a strong social

> network. She travels ALONE for Pokemon events. She was described as being able to plan ahead. She has a driver's license. She was taking classes for ECE and then Accounting. She was slated to work as a ride operator at Great America (I do not see an update regarding if she started or not, just that she was hired). MD wrote that it is her opinion [claimant] never demonstrated bipolar but does not say how she ruled bipolar out. Living skills seem impacted by motivation, not an inability to complete the tasks due to lack of understanding or ability. Alot of her symptoms seem to be due to the ADHD.

Dr. Ellis did not mention Dr. Bradley's very lengthy and detailed report, suggesting that she did not review it, or the more recent report from Chau, both of which described claimant's inability to complete the Great America ride operator training. At hearing, the hearing officer asked what documents Dr. Ellis had been sent, and SARC's representative stated he sent her the exhibit bundle from hearing. Regardless, this brief email from Dr. Ellis has little probative value.

Ultimate Factual Findings

55. Claimant has established that she meets the criteria for an ASD diagnosis, that she was diagnosed with autism prior to the age of 18, and that this is a lifelong condition. The expert opinions of Dr. Bradley were credible, persuasive, and unrebutted. Dr. Bradley conducted a comprehensive psychological evaluation of claimant in 2026 including an in-depth clinical interview with claimant, a mental status examination and psychological assessments of claimant, historical records review, and collateral interviews with claimant's parents, behavior analyst, and treating psychiatrist.

Dr. Bradley also persuasively explained the deficiencies in Dr. Luke's 2014 evaluation. The opinion of Dr. Bradley that claimant has ASD were also consistent with those of claimant's treating psychiatrist and therapist.

56. Claimant has also established that ASD constitutes a substantial disability for her, creating significant functional limitations in four areas of major life activity: self-care, self-direction, capacity for independent living, and economic self-sufficiency. The observations and opinions of Dr. Bradley and Chau as to claimant's functional limitations were credible, persuasive, and unrebutted. The testimony of claimant's mother, and her contemporaneous email communications regarding claimant's functional limitations, were credible and consistent with the expert opinions and other documentary evidence.

SARC's October 2025 denial letter includes a statement that: "Significant functional limitations by regional center standards are individuals who are in the 'extremely low range' of adaptive functioning." However, this benchmark is not found in either the Lanterman Act or its regulations, and no evidence was received at hearing to support that statement.

SARC contends that the Lanterman Act requires that the claimant's significant functional limitations must arise prior to the age of 18. However, that requirement is not supported by the text of the statute and regulations. Regardless, the evidence shows claimant did have significant functional limitations in these areas before age 18.

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LEGAL CONCLUSIONS

1. In a proceeding to determine whether an individual is eligible for regional center services, the burden of proof is on claimant to establish that he or she has a qualifying developmental disability, by a preponderance of the evidence.

2. The State of California accepts responsibility for people with developmental disabilities under the Lanterman Act. (§ 4500, et seq.) The purpose of the Lanterman Act is to rectify the problem of inadequate treatment and services, and to enable people with developmental disabilities to lead independent and productive lives in the least restrictive setting possible. (§§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

3. The term "developmental disability" includes intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability (the "fifth category"). (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (a).)

A developmental disability must originate before the individual reaches age 18; must continue, or be expected to continue, indefinitely; and must constitute a substantial disability for that individual. (§ 4512, subd. (a); Cal. Code Regs., tit. 17, § 54000, subd. (b).)

Under the Lanterman Act, handicapping conditions that are solely psychiatric in nature, solely learning disabilities, or solely physical in nature are not considered

developmental disabilities. (Cal. Code Regs., tit. 17, § 54000, subd. (c).) However, services are not to be denied to a claimant with a learning disability or psychiatric disorder, so long as the claimant can also establish a qualifying condition under the Lanterman Act. (*Samantha C. v. Department of Developmental Services* (2010) 185 Cal.App.4th 1462.)

4. "Substantial disability" means major impairment of cognitive and/or social functioning, and the existence of significant functional limitations, as appropriate to the person's age, in three or more of the following areas of major life activity: receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (§ 4512, subd. (l)(1); Cal. Code Regs., tit. 17, § 54001, subd. (a).)

5. A preponderance of the evidence established that claimant has an eligible condition, ASD, that originated before she reached the age of 18, and that is expected to continue indefinitely. (Factual Finding 55.)

6. A preponderance of the evidence established that claimant has significant functional limitations in the areas of self-care, self-direction, capacity for independent living, and economic self-sufficiency, and that these are attributable to her ASD. (Factual Finding 56.)

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

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ORDER

Claimant's appeal is granted. Claimant has established her eligibility under the Lanterman Act to receive services from SARC.

DATE: 09/25/2026

HOLLY M. BALDWIN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 within 15 days of receiving the decision, or appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.