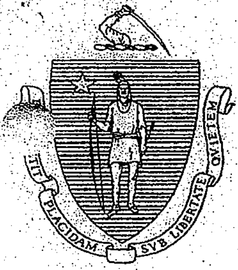

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
500 Harrison Avenue
Boston, MA 02118

Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary

Elin M. Howe
Commissioner

Area Code (617) 727-5608
TTY: (617) 624-7590

March 18, 2008

Frederick M. Misilo, Jr., Esq.
Counselors At Law
Fletcher, Tilton & Whipple, PC
370 Main Street, 12th Floor
Worcester, MA 01608-1779

Re: Appeal of [redacted] Final Decision

Dear Attorney Misilo:

Enclosed please find the recommended decision of the hearing officer in the above appeal. A fair hearing was held on the appeal of your client's eligibility determination.

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's recommended decision, I find that it is in accordance with the law and with DMR regulations. Your appeal is therefore denied.

You, or any person aggrieved by this decision may appeal to the Superior Court in accordance with Massachusetts General Laws, Chapter 30A. The regulations governing the appeal process are 115 CMR 6.30-6.34 and 801 CMR 1.01-1.04.

Sincerely,

Elin M. Howe
Commissioner

EMH/ecw
cc: Jeanne Adamo, Hearing Officer
Richard O'Meara, Regional Director
Marianne Meacham, General Counsel
John Geenty, Assistant General Counsel
Frederick Johnson, Psychologist
Stephanie Kelly, P.O. Box 206, Monument Beach, MA 02553
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL RETARDATION

In Re: Appeal of

This decision is issued pursuant to the regulation of the Department of Mental Retardation (DMR or Department), (115CMR 6.30 – 6.34) and M.G.L. c. 30 A. A fair hearing was held on February 28, 2008 at the Department of Mental Retardation's Glavin Regional Center in Shrewsbury, Massachusetts.

Those present at the proceeding were:

	Mother
	Step-Father
John C. Geenty, Jr., Esq.	Counsel for DMR
Fredrick Johnson, Psy.D.	Eligibility Psychologist for DMR

The evidence consists of documents submitted by the Appellant numbered A1- A2, documents submitted by DMR numbered D1- D5 and approximately two and one half hours of testimony. The documents submitted into evidence are as follows:

Appellant Exhibit #1-
Psychological Assessment conducted by Dr. Rick Sprague, PhD dated February 2, 2008. using the Stanford-Binet Intelligence Scales, 5th Edition.

Appellant Exhibit #2-
Dr. Fredrick Johnson's Eligibility Report with additional information, added by , to more accurately describe the Appellant's diagnosis.

DMR Exhibit #1-
Curriculum Vitae of Fredrick V. Johnson, Psy. D

DMR Exhibit #2-
Psychological Assessment conducted by Leslie Sullivan, M.Ed., C.A.G.S. dated April 24, 2001 using the WISC III 3rd Edition

DMR Exhibit #3-
Psychological Assessment conducted by Leslie Sullivan, M.Ed., C.A.G.S. dated January 10, 2004, using the WAIS III 3rd Edition.

DMR Exhibit #4-
Adaptive Behavior Assessment System (ABAS-II) completed by parent, Ms. dated February 23, 2006.

DMR Exhibit #5-
Eligibility Report of Fredrick V. Johnson, Psy.D., dated January 17, 2006 (updated February 27, 2008)

ISSUE PRESENTED:
Whether the Appellant is eligible for DMR services by reason of mental retardation as defined in 115 CMR 6.04(1) [1]

BACKGROUND:
The Appellant, Ms , is a 21 year old female who resides with her mother, Ms. , has been diagnosed with moderate left hemi paresis, seizure disorder, non-verbal learning disorder, homonymous hemaniopsia, Cerebral Palsy, Arnold Chiari malformation, and hydrocephalus. She attends the Borne high School.

Ms. was eligible for children's services through the Department of Mental Retardation. She applied for DMR adult services after turning age 18 and was found to be ineligible for DMR Adult Services on January 17, 2006. DMR denied the request for adult services based on a failure to meet the criteria for a diagnosis of mental retardation as defined in 115 CMR 2.01 prior to June 2, 2006. Because the applicant's application for DMR supports was filed before June 2, 2006, the earlier standard applies. [1]

An appeal of the denial of services was submitted and an informal conference was held on August 21, 2006 where her ineligibility finding was upheld. She appealed that decision and pursuant to DMR regulations a fair healing was scheduled. The Appellant, was unable to attend the fair hearing due to illness. Ms. mother of the Appellant, served as the Appellant's authorized representative at the fair hearing.

SUMMARY OF THE EVIDENCE PRESENTED:

1. APPELANT's OPENING STATEMENT:
   Ms. made the opening statement as the appellant representative. She explained that she was not an attorney but was speaking as a parent and advocate for her daughter. She stated that it was her firm belief that should receive DMR services. She listed 5 areas/questions that she felt should be considered in making that determination. They are as follows:
   A. Ms ted that she did not know how it was possible for DMR to have considered her daughter to be mentally retarded all through her childhood and then, without ever evaluating miraculously at age 18 decide that she was no longer mentally retarded.

   B. Ms ointed out that she felt Dr. Johnson's eligibility report was not as complete as it should be in listing out diagnosis. There were several neurological issues that were not mentioned in the report section that referenced diagnosis, and Ms. Kelly felt listing them would make a difference in getting a better picture

of her daughter's situation. [redacted] subsequently added the conditions that had not been listed in the margins of a copy of the Eligibility Report and submitted it as Appellant Exhibit #2.

C. [redacted] had an issue with the IQ testing that DMR relied upon to make their determination about Sylvia's intellectual level. She stated that both tests were performed by the Borne Public School District and that caused her concern. It was her opinion that the school always tries to alleviate their financial burden of providing services to children with disabilities and she was worried that the need to control costs may have influenced the results of the IQ testing done by the school.

D. [redacted] felt that it was not possible to really know her daughter's level of ability without meeting her. She stated that no DMR person ever came to her for intake; no DMR person ever sat with her to ask particular questions about [redacted] She stated that Bob Reed from DMR sent paper work to be filled out by her and then came to a vocational IEP meeting for a few minutes. She did not feel that it was possible to form an accurate view of [redacted] based on this limited knowledge.

E. [redacted] was distressed that [redacted] actual functional level is never discussed by DMR in making their determination of ineligibility. She did not believe that the determination should be made strictly based on an IQ number. Ms. [redacted] stated that people cannot be judged by one number.

2. The Hearing Officer asked Dr. Johnson if the questions/concerns that Ms. [redacted] had raised are questions that are intended to be covered at an informal conference. Dr Johnson stated that the informal conference was held so long ago that he could not recall what had been discussed but that they do respond to any questions that are asked. Ms. [redacted] stated that if [redacted] had been present at the informal conference she ([redacted]) would have been reluctant to speak about her daughter's deficits in her presence. Ms. [redacted] felt strongly that such discussion could negatively impact upon [redacted] self esteem.

3. Before making his opening statement, attorney John Geenty asked Dr. Johnson to explain DMR's regulatory requirements for children's services verses adult services. Dr. Johnson stated that children who reside in Massachusetts are eligible for regular services from DMR in two ways; the child could either (1) meet adult criteria for a diagnosis of mental retardation with an IQ of 70 or below along with significant deficits in adaptive behavior that are due to significant deficits in intellectual functioning, or (2) the child could be diagnosed with a developmental disability that has had an impact on intellectual functioning. Dr. Johnson stated that although he

5. Attorney Geenty notified the Hearing Officer of a phone call received from the Appellant's attorney, Fred Misilo, stating that a new IQ assessment would be presented at this hearing. Ms. [redacted] confirmed the existence of a recently completed assessment conducted at the appellant's expense and stated that she did wish to submit the new assessment as evidence. She also wished to submit for the record, a copy of her revised DMR Eligibility Report with additional diagnoses listed in the margins. The following documents were photocopied, given to all parties and submitted as Appellant Exhibits #1 and #2:

Appellant Exhibit #1-
2/4/2008 Standford-Binet Intelligence Scales, 5th Edition
Completed by Rick Sprague, PhD

Section	Standard Score	Confidence Interval
Nonverbal IQ	83	78-90
Verbal IQ	80	75-87
Full Scale IQ	80	76-84
Reasoning	97	89-105
Knowledge	83	76-92
Quantitative	81	75-91
Visual-Spatial	74	68-84
Working Memory	83	77-93

Appellant Exhibit #2-
DMR's 1/17/06 Eligibility Report with the following medical facts added to the diagnostic section:

- Moderate left hemi paresis
- Homonymous Hemaniopsia
- Cerebral Palsy
- Arnold Chiari Malformation
- Hydrocephalus

6. APPELLANT'S TESTIMONY:
Ms. [redacted] called Dr. Johnson as a witness.
Dr. Johnson was questioned about the method that is used to come to a Full Scale IQ figure, specifically if the subtest scores were averaged to determine a Full Scale Score. Ms. [redacted] was concerned about the large discrepancy between the Verbal score of 80 and the Performance score of 60 in the 4/24/01 Wechsler Intelligence Scale for Children – 3rd Edition (WISC-III). Dr. Johnson stated that the scores were not averaged. It would be difficult to exactly explain the statistical method but that the scores are determined by the use of tables. The examiner gets a raw score in all the sub tests which are converted into standard scores using a chart and these

scores are then compared to another chart to determine a final score that is converted to adjust for the child's age. The final numbers become the Verbal IQ score, the Performance IQ score and the Full Scale IQ score.

Dr. Johnson was questioned about why a person who is functioning at a Peformance Score of 60 would not be considered retarded based on this score alone. Dr. Johnson stated that DMR's definition of Mental Retardation require that the Full Scale IQ is below 70. He further stated that some people do not have a Performance Scale tested at all due to medical constraints that would render that particular score less valid. For example sometimes practitioners would not use the Performance portion of the test for people with Cerebral Palsy because the Performance section is sensitive to time and manipulation of task. The feeling is that the person being tested would be penalized because of their motor capacity and not because of their intellectual capacity.

Dr. Johnson was questioned as to how he makes a determination of mental retardation without knowing the person, without actually evaluating the person and without considering the person's functionality as a key piece of the determination. Ms. [redacted] noted that it was apparent to her and [redacted] step-father and also apparent through the results of the Department's Adaptive Behavior Assessment (ABAS II) as well as Dr. Sprague's evaluation, that [redacted] would need life long supports. Ms. [redacted] pointed out that the supports that [redacted] needed were not costly but they are necessary, and that although [redacted] does better some areas such as the verbal section of testing, she is not competent in many other areas. Ms. [redacted] noted that she and [redacted] step-father were aware of many people with higher IQ's who were receiving DMR supports. She questioned why others with a higher IQ could receive DMR supports and her daughter with her many functional limitations was refused; she questioned Dr. Johnson as to the Department's ability to be subjective about a person's diagnosis of mental retardation.

Dr Johnson stated that the Department hires licensed psychologists that follow professional standards required by virtue of licensure. Determination of eligibility is made according to professional practice and regulation. Adaptive behaviors are considered when caused by an intellectual deficit. As a licensed psychologist he must follow accepted practice and use only accepted diagnostic evaluations. He stated that there is some allowance for some discretion around the standard of measurement when assessing the results. This practice is important when you have just one test. The more testing that is done, the more testing that can be assessed and compared, the more likely it is that a psychologist can determine a value closer to the person's true score.

Dr. Johnson stipulated that you never get a true score because a person can have a good day or a bad day, perhaps get less sleep on a particular day and not test as well. Dr. Johnson stated that he does use discretion in his decisions and he did use discretion in coming to a decision about [redacted]. He was aware that [redacted] had multiple diagnoses and it is a factor in understanding why she may have cognitive difficulties. Dr. Johnson explained there are certain limits as to whether [redacted] can be labeled mentally retarded regardless of her other diagnoses. To be eligible for

adult DMR services, she must meet DMR's definition of mentally retarded which requires an IQ of 70 or below.

7. DMR'S TESTIMONY:
Dr. Johnson testified as an expert witness for DMR.
Dr. Johnson testified that he is employed by DMR in Carver, Massachusetts, and that he is also an Assistant Attending Psychologist at McLean Hospital in Belmont, Massachusetts. Dr. Johnson stated that his primary responsibility at the Department of Mental Retardation entails eligibility determinations where DMR Eligibility Specialists go out to the field to collect information from families and present a completed packet of information to him. He then makes a determination as to whether or not the person meets DMR's criteria for services based on the papers before him. The information that is gathered includes all IQ tests and medical reports that are available, and although it was not always the case, it now includes an Adaptive Behavior Assessments (ABAS II) completed by the family.

Dr. Johnson stated that he is a licensed psychologist and holds a doctor of Psychology from Nova Southeastern University. After reviewing Dr Johnson's educational and professional credential (DMR Exhibit #1) the Appellant stipulated to Dr. Johnson's qualifications as an expert witness in the field of Mental Retardation.

Dr. Johnson stated that around November 2005 the eligibility office received the appellant's application for adult DMR services. Dr. Johnson stated that the earliest psychological assessment was conducted by Leslie Sullivan, M.ED., C.A.G.S., Certified School Psychologist at the Bourne public Schools on April 21, 2001 when the Appellant was age 14 ½ years. The evaluation instrument used was the WISC-III psychological evaluation and it showed a Verbal IQ of 80, a Performance IQ of 60 and a Full Scale IQ of 68 (DMR Exhibit #2). Dr. Johnson stated that Sylvia did fairly well in abstract sub testing . He stated that a verbal IQ of 80 indicates strength in vocabulary and that is inconsistent with what you would usually see with someone who is mentally retarded. He noted a variability of 20 points which indicates a great variability in what the appellant can and cannot do. Dr. Johnson stated that even with the Appellant's strengths she did poorly overall with a score of 68, however the overall functioning score of 68 does not tell the whole story. Dr. Johnson stated that the fact that the Appellant did poorly in performance could be due to the fact that she has Cerebral Palsy; it could be that she was penalized because of speed. On the other hand, it may be that she was not penalized by time at all and that she has difficulties in those particular areas as a result of the Cerebral Palsy. Dr. Johnson stated that he cannot tell if Cerebral Palsy is the reason for the low score. Dr. Johnson said that by his training, if Cerebral Palsy was a large issue, the Performance section of the test should not have been given. However, at that point in time, as a child of 14 years, the Appellant would be eligible for DMR services based on disability. Dr. Johnson stated that a professional administering the test should accommodate for a disability so that the test results indicate what the test is designed to do, which is, to test the cognitive capacity in different areas. If an accommodation

is not made it could impact the results and, although the test will indicate what the individual can actually do, it will not capture the cognitive abilities of that individual. One example is the issue of speed for someone who has a physical limitation in that area such that could be the case with Cerebral Palsy, and another example is the issue of vision for someone who has a problem seeing the testing instrument.

The Hearing Officer asked if Dr. Johnson would consider the Appellant a person with mental retardation if looking just at this test and the Full Scale IQ of 68. Dr. Johnson stipulated that a Full Scale IQ Score of 68 did meet the requirement for mental retardation. Dr. Johnson stated that if only looking at this WICS-III test alone, mentally retardation could be a possibility but would have to be further investigated as to whether or not she was penalized because of her Cerebral Palsy.

Dr. Johnson stated that the WAIS III 3rd edition (DMR Exhibit #3) with a Verbal IQ 82, Performance IQ of 73, and Full Scale IQ of 76, administered to the Appellant at age 17 years 3 months, shows some sub test results that have changes over time. The content of this test (WAIS III 3rd edition) is a little different than the test that is given to people at a younger age (WISC III 3rd Edition). The Appellant did less well in some areas and improved in other areas, in addition the point difference between scores has reduced from 20 in the earliest test to 9 in this test. Dr. Johnson could not hypothesize as to why this would be the case other than to say that the Appellant may be variable in how she does from one day to the next.

Dr. Johnson stated that the Appellant seems to have improved over time in terms of her capacities. Dr. Johnson came to this determination by comparing the three IQ test results: the results of the 1/10/04 WISC-III (DMR Exhibit #2); the results of the 2/23/06 WAIS-III (DMR Exhibit #3); and the results of the 2/4/2008 Stanford-Binet Intelligence Scales, 5th Edition (Appellant Exhibit #1).

Dr. Johnson described the Adaptive Behavioral Assessment System (ABAS II) assessment. It is a test that is filled out by a family member. Ms. [redacted] confirmed that she had answered the questions in the 2/23/06 ABAS II (DMR Exhibit #4) regarding her daughter's adaptive behaviors. Dr. Johnson explained that the scores from the questions in the form that are answered by a person who is familiar with the individual are calculated, the raw scores are converted to scaled scores, and finally the scaled scores are converted to 4 areas that make up the "Composite Scores". The four areas that make up the Composite Scores are (1) GAC Score which is the overall score that the person receives as a composite of the adaptive functioning, (2) Conceptual Score which is a cluster area made up scores from the Communication, Functional Academic, and Self Direction areas of the test, (3) Social Score which is a cluster area made up of scores from the Leisure Skills and Social Skills areas of the test, and (4) Practical Score which is a cluster area made up of the scores from the Community Use, Home Living, Health & Safety and Self Care areas of the test. Dr. Johnson stated that this test is not very scientific and it is not comprehensive. It is a test that gives an indication of what a person can do and what the person cannot do; it does not cover everything. Dr. Johnson stated that it is intended to be just a sampling of the person's adaptive behaviors. It is also valuable as a test that results in scoring which allows everyone to get compared using the

same measure.

The Appellants converted scores from the 2/ 23/2006 ABAS II test were 54 for the overall GAC score, 61 for the Conceptual score section, 75 for the Social score section, and 40 for the Practical score section.

The Hearing Officer asked if the Appellant would fall in the range of mental retardation based on the requirement of a need for specialized supports in at least three adaptive skill areas that are required in the DMR regulation effective prior to June 6, 2006.

Dr. Johnson stated that if the appellant met the IQ requirement for the definition of mental retardation, these adaptive behavior assessment scores would be considered and would fall into the range that is necessary in order to be diagnoses with mental retardation.

Dr. Johnson read the requirements for general eligibility for DMR supports as stated in 115 CMR 6.04 prior to June 2, 2006, at the request of the Hearing Officer and for the benefit of the appellant. A copy of the same was made available to the appellant. The regulation for general eligibility prior to June 2, 2006 is as follows:
(1) Persons who are 18 years of age or older are eligible for supports provided, purchased, or arranged by the Department if the person:

(a) is domiciled in the Commonwealth
(b) is a person with mental retardation as defined in 115 CMR 2.01, and
(c) is in need of specialized supports in three or more of the following seven adaptive skill areas: communication, self-care, home living, community use, health and safety, functional academics, and work.

Dr. Johnson stated that in making a determination of eligibility he reads the entire file to see if there are things in the file that may make him question why the person did well now and not so well in the past. For example, to see if the person was on medication at one point or not on medication at another point. Dr. Johnson stated that although he would have liked to see more testing as more testing would have been helpful to better understand what is going on with the Appellant, he did not have so little information that he could not make a determination as to eligibility for DMR adult services. Dr. Johnson stated that in his opinion the Appellant does not meet the criteria; the Appellant scored in the mentally retarded range of intellectual functioning in childhood, appeared to benefited from educational supports provided by both the school system and the parents, and is now scoring out of the mentally retarded range.

Dr. Johnson stated that the evaluation conducted on 2/4/2008 by Dr. Rick Sprague using the Stanford-Binet Intelligence Scales, 5th Edition, resulted in a Full Scale IQ score of 80, a Nonverbal IQ score of 83 and a Verbal IQ score of 80 (Appellant Exhibit #1). Dr. Johnson said that the 5th Edition was the latest version of this test and that although had not personally used it as of yet, he was aware that the standard deviation has changed and is now analogous to the WAIS. Dr. Johnson stated that historically the Stanford-Binet IQ evaluation was better, in general, in discriminating

differences in people with low intelligence, and that he often suggests the use of a Stanford-Binet IQ evaluation for individuals who are on the cusp of eligibility. He makes this recommendation because the Stanford-Binet is better in discrimination of lower intelligence whereas the WAIS IQ evaluation is, in general, a better test to use with people at the higher level of intelligence. Dr. Johnson stated that having the results of a Stanford-Binet in cases that are questionable allow him to feel more comfortable that he has a good picture of the person's intellectual capacity. Dr. Johnson noted that there was little discrepancy between the full scale IQ score of 80, the Nonverbal score of 83 and the verbal score of 80 in the Stanford-Binet administered to the Appellant. Dr. Johnson stated that his opinion about the Appellant's ineligibility for DMR adult services remains unchanged and would not have changed had he had the results of the Stanford-Binet at the time that his initial decision was made in 2006.

8. APPELLANT's CROSS EXAM

Ms. [redacted] stated that, in her opinion, the 20 point differential in the WISC (DMR Exhibit #2) would not have been affected by [redacted] vision and disagreed that it could be due to Cerebral Palsy. She stated that [redacted] has 20/20 vision and that the lower score was not due to a physical issue but rather that [redacted]'s problems with abstract ideas. Ms. [redacted] stated that she found it amazing that an IQ could have jumped so many points in only 3 years and asked Dr. Johnson's opinion as to whether the cause of a higher or lower score could be in relation to the testing environment or the impact of medical issues rather than an increase in IQ. For example if the person had a day where he/she felt better physically with less tremors. Dr. Johnson stated that in his opinion a person could not score higher because of good test conditions; however, the person could score poorer because of bad test conditions. Dr. Johnson stated that a person cannot answer a question or do a task that he/she did not know or was unable to do because of good test conditions, therefore a person could not score higher than his/her intellectual ability because of good test conditions. However, a person may not be able to do a task or answer a question that he/she knows how to do because of bad test conditions, for example, if the person had not gotten enough sleep. There is something called sampling error, which means that you can ask questions that a person is more likely to know, but they try to account for this when designing the tests. Dr. Johnson stated that a person could score higher on a day that the person was feeling especially well as compared to a day when the person was not feeling well. However, it was his opinion that the person could not score higher than his/or her intellectual capacity irregardless of how the person felt on a particular day.

Ms. [redacted] asked Dr. Johnson to explain what a standard deviation was and asked whether he allowed for any variation in the score when making a determination of mental retardation, for example, plus or minus 5, or was the IQ number the number without any significance given to variation. Ms. [redacted] stated that she understood that multiple testing would be ideal but paying for multiple IQ assessments was a burden on parents and that it was not fair and not realistic to expect that parents would have the funds to do so.

Dr. Johnson offered an abbreviated overview of standard deviation. Dr. Johnson explained that, for example, in the ABAS, a standard deviation is 15 points and it is looked at in relation to the an average (mean) score of 100; a standard deviation is seen as a significant jump from one category to the next. One standard deviation below the mean would be a score of 85 and two standard deviations below the mean would be a score of 70. DMR defines cognitive functioning for mental retardation as a score of two standard deviations below the mean or 30 points below 100 which is a score of 70. As to the variation in the score, more testing allows the psychologist to get a better picture of the person.

The Hearing Officer asked Dr. Johnson if he felt it necessary to obtain additional IQ testing in order for him to come to a determination of eligibility. Dr. Johnson said that he did not need any additional IQ testing in this case.

Ms. [redacted] stated that she filled out the ABAS very honestly and that this ABAS test result was an honest indication of Sylvia's functional ability. Ms. [redacted] stated that she could not understand why DMR would bother to have parents fill out an ABAS if it all comes down only to the IQ number of 70. She questioned why even bother with the ABAS if it does not have any impact in determining the IQ number.

Dr. Johnson stated that if [redacted] had the cognitive functioning low enough to meet the criteria of mental retardation, [redacted] test results in the ABAS would have met the criteria for the definition of mental retardation. Dr. Johnson stated that the low results of the ABAS alone do not change his decision. He stated that he does not only look at the IQ number, that, for example, he has in the past determined that an individual with an IQ of 70 did not meet the definition of mental retardation because the low IQ number was a result of other factors, unrelated to cognitive ability.

Ms. [redacted] questioned the appearance of a conflict of interest in that DMR was paying the Hearing Officer who will be making a determination on the appeal of DMR eligibility. Ms. [redacted] was assured that the hearing is being held in accordance with DMR regulations; no conflict of interest exists and that an impartial decision will be made.

Mr. [redacted] appellant's step-father, was called as a witness. Mr. [redacted] stated that he has known [redacted] ce she was 10 years old. He stated that the full scale IQ does not tell who [redacted] is; she is a person who will need long term follow up supports throughout her life and Mr. [redacted] had always assumed they would be given through DMR. Mr. [redacted] tated that in his opinion, although [redacted] has performed successfully in jobs, she will not be successful permanently; she will always need some kind of vocational intervention. He stated that [redacted] does not have the wherewithal to do the things that are necessary for her success. Case management, medical advocacy, and financial advocacy will always be necessary. Mr [redacted] tated tha [redacted] mother is her rep-payee and her advocate; he is concerned about what will happen when he and [redacted] mother are not around for her later down the road. Mr [redacted] ated that he understood it is not DMR's job

to advocate for every individual but somebody needs to be there. Mr. [redacted] stated that he had always seen [redacted] as someone who legitimately needs case manager services and he had always thought it would come through the Department. Mr. [redacted] pointed to the very low scores of the ABAS stating that [redacted] fell well below 2 standard deviations in adaptive functioning and is a person who would need life long supports.

FINDINGS AND CONCLUSIONS:

After a careful review of all of the evidence, I find that the Appellant has failed to show by a preponderance of the evidence that the standard applied and the procedure implemented by DMR was inadequate. I find that the Appellant has failed to show by a preponderance of the evidence that she meets the DMR eligibility criteria for adult services. It is noted that because the Applicant's application was filed before June 2, 2006, the earlier standard for the definition of mental retardation applies in this matter. [1]

Prior to June 2, 2006, in order to be eligible for DMR supports, an individual who is 18 years of age or older must have met the three criteria set forth at 115 CMR 6.04.

The criteria state that the person must be:
(a) domiciled in the Commonwealth,
(b) a person with mental retardation as defined in 115 CMR 2.01, and
(c) in need of specialized supports in three or more of the following seven adaptive skill areas: communication, self-care, home living, community use, health & safety, functional academics, and work.

There is no dispute that the Appellant meets the first criteria and I specifically find that she meets the requirement of domicile. However, I find that the Appellant is not mentally retarded as that term is defined in 115 CMR 2.01.

By statute, M.G.L. c. 123B, section 1, a mentally retarded person "is a person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the department is substantially limited in the ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community." Consistent with this statutory mandate, DMR adopted the American Association of Mental Retardation (AAMR) standards as the clinical authority to which it refers in determining whether an individual has "inadequately developed or impaired intelligence".

The AAMR standards established a three-prong test:

a) the individual must have significantly sub average intellectual functioning defined as an IQ score of approximately 70 to 75 or below, based on assessments that include one or more individually administered general intelligence tests,

(b) related limitations in two or more of the following adaptive skill areas: communication, self care, home living, social skills, community use, self direction, health & safety, functional academics, leisure and work, and must exist

concurrently with sub average intellectual functioning, and

(c) the individual must have manifested the criteria (a) and (b) before the age of 18.

I find that the Appellant is not "mentally retarded" as that term is used in statute and regulation for the determination of eligibility for DMR adult supports for the following reasons.

The earliest cognitive evaluation of the Appellant in the record before me is that conducted by Leslie Sullivan, M.Ed., C.A.G.S., dated April 24, 2001 when the Appellant was 14 years old (DMR Exhibit #2) . At that time the Appellant was administered the Wechsler Intelligence Scale for Children- Third Edition (WISC III). The scores from this test are as follows: Verbal IQ 80, Performance IQ 60, Full Scale IQ 68. I find that although the Full Scale IQ score falls well within the range required for a determination of mental retardation, the high Verbal IQ score of 80 along with the significant discrepancy of 20 points between sub scores must be noted and further assessed in relation to other testing.

The appellant was next tested on January 10, 2004 when she was 17 years old. This cognitive assessment was also performed by Leslie Sullivan, M.Ed., C.A.G.S (DMR Exhibit #3) The test administered was the Wechsler Adult Intelligence Scale- third Edition (WAIS III). She achieved the following on the WAIS III: Verbal IQ 82, Performance IQ 73, and Full Scale IQ 76. The clinician who administered the test observed that the results revealed better developed verbal reasoning abilities as compared to nonverbal reasoning abilities. Dr. Johnson's noted that this test reflected less discrepancy between sub scores. The Full Scale IQ score of 76 falls above the upper range 75 referenced in AAMR standards.

The most recent cognitive assessment was submitted by the Appellant as Exhibit #1. The assessment was conducted on 2/4/2008 by Dr. Rick Sprague using the Stanford-Binet Intelligence Scales, 5th Edition (Appellant Exhibit #1). The Stanford-Binet assessment resulted in a Full Scale IQ score of 80, a Nonverbal IQ score of 83 and a Verbal IQ score of 80. Dr. Johnson testified that he often suggests the use of a Stanford-Binet IQ evaluation for individuals who are on the cusp of eligibility. It is his opinion that the Stanford-Binet is better in discrimination of lower intelligence whereas the WAIS III evaluation is, in general, a better test to use with people at the higher level of intelligence. Dr. Johnson testified that the results of a Stanford-Binet allow him to feel more confident that he has a good picture of the person's intellectual capacity. There is little discrepancy between the full scale IQ score of 80, the Nonverbal score of 83 and the verbal score of 80 in the Stanford-Binet administered to the Appellant, further confirming the validity of these results. Dr. Johnson's testimony regarding the preference of the Stanford-Binet testing for situations that are uncertain led to my decision to give more weight to the finding of this assessment. The Full Scale IQ score of 80, Nonverbal IQ score of 83 and Verbal IQ score of 80 fall out of the range referenced in AAMR standards. I therefore find that the Appellant does not meet the requirement of significantly sub-average intellectual functioning.

While there is evidence presented relative to the Appellant's functional limitations in the results of the ABAS evaluation, I did not give consideration to this evaluation in reaching my determination because I found that the weight of the evidence presented relative to the Appellant's intellectual functioning showed that the Appellant does not have significantly sub-average intellectual functioning. Because the Appellant failed to show by a preponderance of the evidence that she met the criteria of the first of three requirements within the AAMR definition of mental retardation, a score of 70 to 75 or below, I did not consider evaluating the second of the three requirements, the Appellant's functional limitations, in reaching my decision. Functional limitations can result from a variety of conditions. Unless the weight of the evidence shows that an individual has significantly sub-average intellectual functioning, it is not necessary to give consideration to such functional limitations.

APPEAL:

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L.c.30A [115CMR 6.34(5)]

Date: March 10, 2008

Jeanne Adamo
Hearing Officer

---

[1] DMR changed its definition of "mental retardation" and the incorporated definition of "significantly sub-average intellectual functioning" effective June 2, 2006. Because the Applicant's application for DMR supports was filed before June 2, 2006, the earlier standard applies.