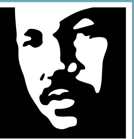
HEALTH CARE FOR THE HOMELESS NETWORK

South King County Showcase

March 16, 2026



Overview

- Programs offer a wide range of services, from outreach and case management to clinical care. And serve a wide range of individuals.
  - African Community Housing and Development
  - Catholic Community Services
  - HealthPoint
  - Peer Washington
  - YMCA
  - Street Medicine (already presented)
- Budgets and program descriptions are specific to HCHN funding, although they have other services/programs not funded by HCHN.

Main contact: Abdinasir Mohamed abdinasir@achdo.org

Our work-HCHN services

- Housing Navigation (Rapid Rehousing & Emergency Shelter)
- Comprehensive Case Management & Care Coordination
- Health Insurance & Documentation Assistance
- Mobile Medical, Dental & Vision Clinic Referrals (No Insurance Required)
- Behavioral Health & Wellness Referrals
- Employment & Job Readiness Support
- Basic Needs Assistance (Food, Clothing, Hygiene)
- Culturally Responsive Community Connections

Abdinasir Mohamed (**Abdi**) is a community organizer and outreach specialist with over 15 years of experience in grassroots advocacy and community engagement. He played a pivotal role in the campaign to establish the $15 minimum wage in SeaTac and has been a strong advocate for affordable housing initiatives. In 2015, Abdi volunteered in building tiny homes across several locations to support individuals experiencing homelessness, demonstrating his long-standing commitment to housing justice and community empowerment.

Client story

- Hassan experienced homelessness for over 7 years in King County. He lacked stable housing, employment, hygiene access, and consistent mental health support.
- With immediate intervention, a $300 emergency assistance was approved to stabilize urgent needs.
- He was then placed in a one-bedroom apartment, renewed his driver's license, completed required screenings, and secured employment as a for-hire taxi driver.
- Today, Hassan is employed, actively saving income, and preparing to independently pay affordable rent after one year of support.
- After seven years on the streets, he has regained stability, dignity, and a clear commitment to never return to homelessness.

Outcome: Transitioned from chronic homelessness to stable housing, employment, and a sustainable path toward full self-sufficiency.

Who we served in 2025

- Number of individuals served: 46
- Key demographics:
  - 91% Black/African American
  - 59% female
  - Primary language: 89% do not speak English as their primary language
    - 39% Somali
    - 13% Amharic
    - 11% Swahili
    - 26% other language

CATHOLIC COMMUNITY SERVICES
OF WESTERN WASHINGTON

Main contacts:

Danequa Brown, Clinical Supervisor DBrown@ccsww.org
Bailey Niall, Clinical Manager BaileyN@ccsww.org

(206) 956-9570 CReW main line

Our work

- **Where we work:** Federal Way, Des Moines, Renton, Kent, Covington, Burien, Auburn
- **What we do**: CReW Behavioral Health Outreach
  - Behavioral healthsSupport, incl. nursing and psychiatric medication mgmt
  - Connection to DSHS/Social Security benefits, housing/shelter, primary care
- Other agency programs
  - CReW Outpatient Mental Health and Substance Use Disorder Services (ages 18+ with active Medicaid); Medications for Opioid Use Disorder (MOUD)
  - Matt Talbot Center
  - Housing (shelter sites + RRH + HEN + Kinship + SPC + SSVF)
  - WISe
  - more: King County | Catholic Community Services of Western Washington

Our staff

- Outreach Case Manager: BC carries the skills of personalization, empathy, CM work, empathy, and a desire to grow and advocate for the community.
- SUD Outreach Case Manager: JP brings heart, dedication, and deep advocacy for the OR field, highlighting the need for SUD support, and is dedicated to meeting clients where they are at. JP uses her personal experience to connect on a deeper level with clients with vulnerability and openness.
- Psychiatric Nurse Practitioner: SB shares time with the OR team, providing nursing care out in the field where needed, meeting clients with empathy, and assisting with medical help/knowledge. She is not afraid to be hands-on with clients in the field. SB shows that trust is possible within the healthcare field.
- Mental Health Provider: DB brings mental health advocacy to the team and community.

Team out in the field

Who we served in 2025

- Number of individuals: 224
- Key demographics:
  - 28% report their race/ethnicity as BIPOC.
  - 56% male, 40% female.
  - 66% currently living on street.

Main contact: Katherine Gudgel kgudgel@healthpointchc.org

Our work

Where we work: From Burien and Renton in the north through Auburn in the south

Our nurses:

- Visit shelters, libraries, day centers and Permanent Supportive Housing sites on a consistent schedule.
- Reach out to everyone in public areas to see if they would like help with health care. In some settings, they knock on doors to reach as many people as possible.
- Assess injuries and illness and provide treatment, if possible, and refer to Urgent Care or primary care as needed.
- Work with medical, behavioral health, and social service providers inside and outside of HealthPoint to connect people to the right kind of care for their needs.
- Help with insurance and finding transportation as well.

Whole Care Clinic

- a very low-barrier clinic within our Auburn Health Center.
- walk-in
- Addiction Medicine, Sexual Health, Refugee Health

Our staff

- HCHN supports 1.6 FTE of nursing in south KC and about 0.15 FTE administrative support. One full-time nurse (RN) rotates to various shelter locations in SKC and one 0.6 FTE nurse works at Thea Bowman Apartments (TBA) in Kent, a Permanent Supportive Housing site.

- The Shelter Nurse has been working with unhoused people for 19 years. During COVID, she led yoga at some of her sites to help people cope with the additional stress of the pandemic on top of her usual work of vaccination, chronic care management, etc.

- The HHOT Nurse, who works at TBA, joined our team after losing a family member to homelessness and substance use. She has provided initial Brixadi injections for over a dozen people at TBA. Her warmth and kindness help break the ice with clients. She uses her care coordination skills to schedule and remind patients of appointments with health care and social service providers that don't visit their residence.

Sonja at Booker House

DK was a patient at Whole Care, living at a PSH site in Auburn. Sonja provided foot care there. Once, DK told Sonja she wasn't feeling well, but she didn't want to go to the ED. The RN listened to DK's lungs and suspected pneumonia. With DK's permission, she called DK's PCP and both providers convinced DK to go to the ED. She was hospitalized with pneumonia for 2 weeks but is doing great now!

Who we served in 2025

- Number of individuals: 287 (SKC)
- Key demographics:
  - 50% over the age of 50.
  - 45% reported their race/ethnicity as BIPOC.
  - 6% speak primarily a language other than English.

Main contact: Nimo Abdullahi, Program Manager Nimoa@peercommunity.org 253-656-2723

Our work

Where we work: Renton, Federal Way libraries (HCHN sites)

What we do: Peer Services Specialists

- provide compassionate peer emotional support to individuals facing mental health, substance use disorder challenges, homelessness, and justice-involvement.
- provide resource navigation and connect individuals to services.
- create safe, judgment-free spaces.

Client story

When Tony first met "Gerald," he was unhoused, medically fragile, and living in extreme vulnerability. Through steady support and fierce advocacy, Tony supported Gerald in securing safe housing, restoring dignity, stability, and a place to call home. Although Gerald later passed away after multiple strokes, he spent his final days sheltered, cared for, and not alone on the streets.

Who we served in 2025

- Number of individuals: Federal Way library-110, Renton library-189
- Key demographics (of all clients served at KC libraries):
  - 53% identify their race/ethnicity as BIPOC.
  - 58% male, 31% female
  - 75 clients disclosed non-binary gender identity
  - 50% currently living on street

Main contact: Kristina Miller ktmiller@seattleymca.org

Our work

Where We Work: Arcadia Shelter & Drop-in Center, offered by Y Social Impact Center

932 Auburn Way South, Auburn, WA 98002

What We Do: HCHN provides comprehensive support across Arcadia services:

- Basic client needs such as hot meals, showers, and laundry
- Coordinated linkages to mental health and substance use disorder counseling.
- Financial assistance for essential items—clothes, shoes, phones—anything that helps clients regain stability.
- Behavioral Health Liaison (BHL) works closely with clients to connect them with services and to ensure awareness of the HMC Youth Clinic, which operates in the admin building and offers no-cost health care. These efforts create streamlined pathways to care and housing stability.

HCHN supports all clients that are homeless in SKC, our BHL works with providers from our transitional living programs to ensure the young adults in those programs have supports.

Our Team

HCHN funds a full-time Behavioral Health Liaison and partial time for a Program Director and a Case Manager.

Behavioral Health Liaison: Guided by perseverance and deep community insight, **Yary** crafts programs that empower youth with durable, community-centered opportunities. In Yary's free time she enjoys MMA, her dogs and baking.

Program Director: Kristina leads with lived experience, turning empathy into systemic change that empowers young people to thrive. In Kristina's free time she enjoys pottery, candles and swimming.

Our team where the work happens

Sky’s story

Sky’s journey began on 8/20/2024 when he became homeless after he went to jail for the first time following a fight with his sister’s boyfriend that led him to Arcadia. ***"when i got here it was rough, it was tough it kinda sucked and then I went to jail again I got falsely accused by my partner at the time. I spent 2 months in jail, I then got out and had a quick turn around for housing. And now I am here I am going back to school I got a place. I am getting ABD." "I also got a really good case manager, the shelter services in general were helpful.”***

Sky’s story shows how **virtual advocacy, resources, and the fast pace of our housing team can accelerate progress**. Sky worked with our Behavioral Health Liaison, who referred him to mental health services. They were able to document his disabling condition, which helped place him into Permanent Supportive Housing, where he is permanently housed. He now works with his primary case manager on **life skills, personal goals, education and employment linkages**. Our Behavioral Health Liaison supports his overall well being with **mental health supports and connection**.

Who we served in 2025

- Number of individuals: 175 (through 6/30/25)
- Key demographics:
  - 90% are 18-24 years old
  - 57% report their race/ethnicity as BIPOC.
  - 26% report sexual orientation/gender minority (e.g., gay, lesbian, trans, queer, non-binary, etc)

Questions and Discussion