

b-present Support Starter Kit Intake Form (Preview)

Eligibility Check

Eligibility Checklist

- Patient is currently between the age of 18-40
- Patient currently lives in the United States
- Patient is newly diagnosed (within the last 6 months) or in active treatment
- Patient has not previously participated in the support starter kit program
- Patient is able to read and understand English

Eligibility confirmed / Not Eligible

Form provided if eligibility is confirmed

SUPPORT STARTER KIT SIGN UP QUESTIONNAIRE

What is your relationship to the patient?

- I am the patient
- I am a health professional
- I am a supporter (friend or family member)
- other

Patient Permission

Does the patient know you are signing up on their behalf?

- Yes
- No

Patient Information

Patient Name

Patient Email

Delivery Location

Where should the Welcome Kit be delivered?

- Home address
- Hospital or Clinic

Mailing Address

Please provide a current address where the kit can be received within the next 2-3 weeks.

Special Mailing Instructions

For example: front desk delivery, unit name, or other helpful notes.

Community Type

Which best describes the area where the patient currently lives

- Urban (city)
- Suburban (residential outside the city)
- Rural (small town or countryside)

COMMUNICATION PREFERENCES

Patient internet access

Does the patient have access to a mobile device and internet?

- Yes
- No
- Unsure

Notification Preferences

How would the patient prefer to receive updates?

- Email
- Text
- Both

Mobile Phone number

Used only for Support Starter Kit notifications if txt preference is selected.

ABOUT THE PATIENT

These questions help us build inclusive, relevant resources.

Age

What is the patient's age range?

- 18-20
- 21-24
- 25-29
- 30-34
- 35-40

Gender

What best describes the patient's gender?

- Man

- Woman
- Non-binary
- Another identity
- Prefer not to say

Sexual orientation

What best describes the patient's sexual orientation?

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Straight
- Other sexual orientation
- Prefer not to say

Race and ethnicity

How does the patient identify racially or ethnically? (Select all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- White
- Another identity
- Prefer not to say

PATIENT TREATMENT EXPERIENCE

These questions help us better understand what the patient's days look like so we can tailor support.

Treatment Experience

- Primarily Inpatient (overnight hospital stay)
- Primarily Outpatient (appointments, infusions, clinic visits)
- A mix of inpatient and outpatient care
- Unsure / Not Yet Known
- Prefer not to say

Which option best describes the patient's current treatment experience?

Patient Commute

What is the approximate distance between home and the main treatment location? (If treatment is primarily inpatient, select "0 miles")

- 0 miles - currently inpatient
- <10 miles
- 10-25 miles
- 26-50 miles
- 51-100 miles
- > 100 miles

Year Diagnosed

What year was the patient diagnosed?

- 2025
- 2024
- 2023
- Before 2023
- Prefer not to say

HEALTH PROFESSIONAL CONTACT INFORMATION

This information helps us confirm eligibility or coordinate kit delivery when needed. The healthcare provider will only be contacted if necessary.

Health Professional Name

Health Professional Email

Used only if we need to confirm eligibility or coordinate in-hospital delivery.

Health Professional Phone

Used only if email follow-up is not possible.

PATIENT INVITED SUPPORT NETWORK

The free Support Starter Kit subscription includes 4 kits:

1 welcome kit + 3 themed kits to enjoy with a selected supporter (delivered every other month).
Please list up to 3 young adult supporters (friends or family) to invite.

Each supporter will receive a welcome kit (we'll verify their address in the email invite), and a themed kit. NOTE: If "0" is selected, no additional kits will be sent beyond the welcome kit (themed kits are provided to encourage connection and be enjoyed with additional supporters). Supporters can always be added later if and when it feels right.

Number of Invited Supporters

How many supporters will be invited to enjoy the Support Starter Kit program with the patient (3 max)?

- 0
- 1

- 2
- 3

Supporter Opt Out Acknowledgement

- Checkbox
- By selecting "0", you understand that no additional kits will be sent beyond the Welcome Kit (Appears only if "0" supporters is selected)

INVITED SUPPORTERS

Please provide Name, Email and Location for each of the invited supporters. Each supporter will receive an email invite and welcome kit (we'll verify their address in the email invite), and a themed kit later in the program.

Supporter 1 (S1) Name

Supporter 1 Email

Supporter 1 Location (Local/Remote)

- Local (within ~50 miles or able to meet in person)
- Remote (farther away or primarily virtual support)
- Not sure

Supporter 2 (S2) Name

Supporter 2 Email

Supporter 2 Location (Local/Remote)

- Local (within ~50 miles or able to meet in person)
- Remote (farther away or primarily virtual support)
- Not sure

Supporter 3 (S3) Name

Supporter 3 Email

Supporter 3 Location (Local/Remote)

- Local (within ~50 miles or able to meet in person)
- Remote (farther away or primarily virtual support)
- Not sure

REQUESTOR INFORMATION

(Filled out if requestor is not the patient) You may be contacted if there are questions regarding the support kit delivery/confirmation.

Requestor Name

Requestor Email

Requestor Phone

Used only if we need help coordinating kit delivery.

PRIVACY ACKNOWLEDGEMENT

Consent

- Checkbox

By checking this box, I acknowledge that I have read and understand [b-present's Privacy Policy](#) and consent to sharing the information provided above for the purpose of receiving the Support Starter Kits and related support information.

SSK Signup date