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| *VAVS logo color Virginia Department of Veterans Services*The Virginia Department of Veterans Services (VDVS) would like to ensure that we are able to access your records to determine you eligibility for the Virginia Military Survivors and Dependents Education Program (VMSDEP). This form gathers all needed information and authorizes VDVS to obtain information from the appropriate Veteran Services Organizations (VSOs).  |
| Veteran Name | Last Name | First Name/MI |
| **SSN** |  | **DOB** |  |
|  |
| **Dependent’s Name** | Last Name | First Name/MI |
| **SSN** |  | **DOB** |  |
|  |
| **Address** |  |  |
| **City** |  | **State** |  | **ZIP** |  |
|  |
| **Email address** |  |  |
| **Home Phone** | **( ) -** | **Best time to Call** |  **AM** | **to**  |  **PM** |
| **Cell Phone** | **( ) -** |  |
|  |
| **I give permission for VDVS to obtain information from the following VSO for VMSDEP processing:** | Please list the VSO that you have appointed as your representative. | Telephone #**( ) -** |
|  |

Please fax this form at the time of your online application submission to:

***Virginia Department of Veteran Services***

***Virginia Military Survivors and Dependents Education Program (VMSDEP)***

***Fax: (804) 786-0809***

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***VDVS USE ONLY:***

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| **Date Received:** | **Staff:** | **Application Number:** |