New Jersey Department of Health   BUDGET REVISION REQUEST

Attach justification for each category revision on a separate sheet

Reporting Agency				Grant Title		

Address				Budget Period FROM: TO:		

City	State	Zip	Grant No.	Account No.	Revision No.

	ROUND OFF TO NEAREST DOLLAR					
BUDGET CATEGORIES	**APPROVED BUDGET**		**REQUESTED CHANGES***		**REVISED BUDGET**	
	Grant Funds	**Other Funds**	**Grant Funds**	**Other Funds**	**Grant Funds**	**Other Funds**
A. PERSONNEL COST						
Salaries/Wages						
Fringe Benefits						
Total						
B CONSULTANT/PROFESSIONAL SERVICES COST						
Total						
C. OTHER COST CATEGORIES						
Office Expense and Related Cost						
Program Expense and Related Cost						
Staff Training and Education Cost						
Travel, Conferences and Meetings						
Equipment and Other Capital Expenditures						
Facility Cost						
Sub-Grants						
Total						
Total Direct Cost						
Indirect Cost						
Total Cost						
Less Program Income						
NET TOTAL COST						

Name of Chief Financial Officer	State Approvals
	Yes No Date Signature
Title	Program Mgmt. Officer ☐ ☐ _____ _____
Signature Date	Grant Management Officer ☐ ☐ _____ _____

FS-57
AUG 12   *Use Plus (+) or Minus (-) signs to indicate additions and subtractions.