Exhibit C

NMMFA Homeless Shelter Program Health Care Authority Income Support Division

BUDGET ADJUSTMENT REQUEST

| CONTRACTOR: | Date: | | |
|---|-------------------------|--------------------------|--------------------|
| | | | |
| Agreement No: | | | |
| ATTAC | H JUSTIFICATION | N NARRATIVE FOR EACH LIN | IE ITEM |
| CATEGORY | LINE ITEM | AMOUNT OF INCREASE | AMOUNT OF DECREASE |
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| | TOTALS | \$ | \$ |
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| I certify that the above is required for effi | cient program operation | 1. | |
| | | | |
| Authorized Signature: | | | Date: |
| FOR HCA USE ONLY | | | |
| APPROVED | DISAPPROVED | | |
| Authorized Signature: | | | Date: |