South Carolina Department of Social Services
Child and Adult Care Food Program
INTERNAL CONTROLS

Institution: ____________________________
Agreement No.: ________________________
Information Current as of: ________________

Accounting System

1. Does the institution use a paper ledger or accounting software? ☐ Paper Ledger ☐ Accounting Software

2. If accounting software is used, please list what type: ____________________________

3. What back-up system is used in the event that the accounting system is not available (theft, property damage, system crash, etc.)?
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Will the institution use a separate bank account for CACFP monies? ☐ Yes ☐ No

5. How will CACFP funds be tracked separately from other institutional funds? (CACFP institutions are required to either use the Summary of Expense form or set up a CACFP fund account within the institution’s accounting system that will track both the revenue and expenses for the food service.)
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

6. What procedure(s) do you use to ensure accuracy when reviewing CACFP records?
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

7. If your organization participates in any other federally funded programs, please check the appropriate box(es) and specify the amount received per month in the space provided. If you check other, please specify program(s) name in the space provided.
   ☐ ABC $ _______________  ☐ Medicaid $ _______________
   ☐ Other $ _______________ Program Name: _______________
   ☐ Other $ _______________ Program Name: _______________

Name of Authorized Representative: ____________________________

Signature of Authorized Representative: ____________________________ Date: _____________